

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8994
CERTIFICATE OF DEATH
14001

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE Maryland COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, M	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 14214 Briarwood Terrace		d. STREET ADDRESS 14214 Briarwood Terrace	
3. NAME OF DECEASED (Type or print) Woodley F. ABELL		4. DATE OF DEATH Month October Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 6th 1878
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months 15 Days 1	
IF UNDER 24 HRS. Hours 15 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert A. Abell		14. MOTHER'S MAIDEN NAME Serena Hayden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 578-22-7003	
17. INFORMANT Sarah R. Abell		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19-3 1967 to 10-24 , 1967 , that (I) (we) last saw the deceased alive on 10-12 , 1967 , and that death occurred at 12:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE D.R. Buey		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) D.C. Buey		22d. ADDRESS 809 Veirs Mill Rd Rockville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-27-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town or county) (State) Wash, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Mattingly		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 131 11th S.E. Wash 3, D.C.		DATE OCT 26 1967	

10/1

TO THE HONORABLE
MEMBERS OF THE
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.
FROM THE
COMMISSIONER OF THE
BUREAU OF REVENUE
DEPARTMENT OF THE TREASURY
SIR:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed amendment to the Internal Revenue Code, relating to the taxation of the income of corporations, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
J. C. [Signature]
Commissioner of the Bureau of Revenue
Enclosed for you are two copies of the proposed amendment to the Internal Revenue Code, relating to the taxation of the income of corporations, as submitted to the Department of the Treasury for its consideration.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14005

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>1/2 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapman Rd - Fawcett & Haines Co.</u>		d. STREET ADDRESS <u>4506 Gaynor Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Erfel</u> First <u>E.</u> Middle <u>Acker, Sr.</u> Last		4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1907</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Orville E. Aker</u>		14. MOTHER'S MAIDEN NAME <u>Nannie B. Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Air Force</u>		16. SOCIAL SECURITY NO. <u>579-03-7235</u>	
17. INFORMANT <u>Mildred E. Aker, wife, same item # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction Acute.</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arterio Sclerosis Severe -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u> <u>years.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/27/67</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-30-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler F. H., 1331 Rockville Pk. Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 31 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14006

14001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Deed in deep 2 passed on by Med. Examiner

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>		c. LENGTH OF STAY IN 1b <u>54 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15701 Pitcheson Lane</u>				d. STREET ADDRESS <u>15701 Pitcheson Lane</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>J. AITCHESON</u> First Middle Last				4. DATE OF DEATH <u>Oct 23</u> Month Day Year 19 <u>67</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 9, 1894</u> 73 yrs.	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Jackson Suit</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Geneva Beall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4201</u>		17. INFORMANT <u>Catherine Hanson, Laurel Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Gen'l Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>16 yrs</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> , 19 <u>49</u> , to <u>10/23</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/20</u> , 19 <u>64</u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>J M Warren</u>				22b. DATE SIGNED <u>10/23/67</u>		22c. PHYSICIAN'S NAME (Type) <u>J M WARREN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10-26-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cem</u>	
23d. LOCATION (City or Town) <u>Calmar Manor Md</u>				23e. REC'D BY REGISTRAR <u>Charles Judge</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>De Witt Caradon Laurel, Md.</u>				25a. DATE <u>OCT 30 1967</u>			

1406

STATE OF TEXAS

1401



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14002

CERTIFICATE OF DEATH

14007

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 11 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Manor Health Care Center		d. STREET ADDRESS 3039 Legation St., N. W.	
3. NAME OF DECEASED (Type or print) First Elva Middle N. Last Allen		4. DATE OF DEATH Month October Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1883
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months 30 Days 16 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Ayres		14. MOTHER'S MAIDEN NAME Adelaide Hammell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Son Laurence R. Allen		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Degeneration DUE TO (b) Cerebral Arterio-sclerosis DUE TO (c) 334x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 1, 1967 , to October 30, 1967 , that (I) (we) last saw the deceased alive on October 24, 1967 and that death occurred at 12:10 A.M. from causes and on the date stated above.			
22a. SIGNATURE Robert T. Thibadeau		22b. DATE SIGNED October 30-67	
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau		22d. ADDRESS 11,000 Old Georgetown Road Rockville, Maryland 20852	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10-30-67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE NOV 1 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

3002

5912

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Nov. 15, 1963

voorstel wett.

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E. Allen

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
14003		CERTIFICATE OF DEATH		14008	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 6300 Poindexter Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH B. ALLMAN		4. DATE OF DEATH Month Oct. Day 3 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1896	9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.	
13. FATHER'S NAME Robert E. Backham		12. CITIZEN OF WHAT COUNTRY? D. C.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Sister Mrs. Henry Latimer Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Cardiac Failure DUE TO (c) Heart Block					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Adenocarcinoma of Uterus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 19 58 , to 10/3 , 1967, that (I) (not) saw the deceased alive on 10/3 , 1967, and that death occurred at 9:30 PM from causes and on the date stated above.					
22a. SIGNATURE Frank Y. Jagers Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/4/67	
22c. PHYSICIAN'S NAME (Type) FRANK Y. JAGGERS JR.		22d. ADDRESS Bethesda, Md. 5707 WISCONSIN AVE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-7-67		23c. NAME OF CEMETERY OR CREMATORY High Street Cemetery	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 9 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

5922

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

14004

14009

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Dickerson</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Dickerson</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route I. R.F.D.</u>		d. STREET ADDRESS <u>Route 1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Carl</u> First <u>Edwin</u> Middle <u>ANDERSON</u> Last		4. DATE OF DEATH Month <u>Oct</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>WM</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07/11/00</u>
9. AGE (In years lost birthday) yrs. <u>67</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter Bldg.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>037-03-7516</u>	
17. INFORMANT <u>Mrs. Marian Anderson Md R.F.D.</u>		Address <u>Dickerson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage Massive, Gastrointestinal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Esophageal Varices with Rupture</u> DUE TO (c) <u>Cirrhosis, Liver</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		22. DATE SIGNED <u>Oct. 13, 1967</u>	
EXAMINER'S NAME (Type) <u>John S. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monacacy</u>	23d. LOCATION (City or Town) (County) (State) <u>Beallsville Montg Md</u>
24. FUNERAL DIRECTOR <u>Wm. B. Hilton</u>		25a. REC'D BY REGISTRAR <u>Barneville, Md</u>	
25b. REGISTRAR'S SIGNATURE <u>John S. Ball</u>		DATE <u>OCT 17 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the ward "pending" in pencil in Item 18. Give Pages 2, 3 and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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[Faint, mostly illegible handwriting in the upper section of the page, possibly representing a list or ledger entries.]

[Faint, mostly illegible handwriting in the middle section of the page.]

[Faint, mostly illegible handwriting in the lower section of the page, including what appears to be a signature or name at the bottom right.]

CERTIFICATE OF DEATH

14005 14010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Evelyn (NMN) Anderson		4. DATE OF DEATH October 27 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-07
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR: Months 27 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk		10b. KIND OF BUSINESS OR INDUSTRY C & P Telephone Co	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Anderson		14. MOTHER'S MAIDEN NAME Mattie Lamb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-01-1883	
17. INFORMANT William L. Anderson		18. ADDRESS 13810 Congress Drive Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease manifest by DUE TO 1. Thrombotic occlusion, left coronary artery (b) 2. Acute anteroseptal myocardial infarction DUE TO 3. Rupture of left ventricle. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/25/67 to 10/27/67 , that (I) (we) lost the deceased on 10/27 19 67 , and that death occurred at 8:55 AM , from causes on the date stated above.			
22a. SIGNATURE John J. Curry		22b. DATE SIGNED 10/27/67	
22c. PHYSICIAN'S NAME (Type) John J. Curry		22d. ADDRESS 10620 Georgia Ave Silver Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 31, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or town) (County) (State) Prince Georges Co, Maryland
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

10000

- Arteriosclerotic heart disease manifest as:
1. Coronary occlusion, left coronary artery
 2. Left ventricular myocardial infarction
 3. Rupture of left ventricle.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14006

CERTIFICATE OF DEATH

14-11

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakma Park</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Sanatorium</u>		d. STREET ADDRESS <u>7011 Sycamore Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>C</u> Last <u>ANDERSON</u>		A. DATE OF DEATH Month <u>OCTOBER</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 29, 1891</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Christian Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Eckstein</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>W.W.I</u>	
17. INFORMANT <u>W.W.I</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GANGRENE OF LEFT FOOT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>DIABETES MELLITIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CEREBRAL HEMORRHAGE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 29, 1965</u> to <u>OCTOBER 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCTOBER 11, 1967</u> , and that death occurred at <u>9:40 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel J. Lewis</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <u>OCTOBER 11, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Samuel J. Lewis</u>	
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 14-1967</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		23d. LOCATION (City or town) (County) (State) <u>Rock - DC</u>	
24. FUNERAL DIRECTOR <u>Northwest Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 16 1967</u>	

60245

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
Item #8 Film #G393 10/18/67ph			
CERTIFICATE OF DEATH			
14007			
14012			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 47-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing & Convalescent Home		d. STREET ADDRESS 1809 Irving Street N. W.	
3. NAME OF DECEASED (Type or print) Henry E. Anderson		4. DATE OF DEATH Month Oct Day 11 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 8/29/1886
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR Months 11 Days 11 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer- Retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? Unobtainable	
13. FATHER'S NAME Unobtainable		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unobtainable		16. SOCIAL SECURITY NO. 577-64-4903	
17. INFORMANT Miss Nell Lambert		Address 2726 Conn. Ave. NW	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 334X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) with senile psychosis			INTERVAL BETWEEN ONSET AND DEATH 3 days 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 60 , to Oct 11 , 19 67 , that (I) (we) lost saw the deceased alive on Oct 9 , 19 67 , and that death occurred at 7:05 PM , from causes on and on the date stated above.			
22a. SIGNATURE Neil P. Campbell		22b. DATE SIGNED 10/11/67	
22c. PHYSICIAN'S NAME (Type) Neil P. Campbell		22d. ADDRESS 1629 Columbia Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/14/67	23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR The S.H. Hines Co.		25a. REC'D BY REGISTRAR Washingon, D. C.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 16 1967	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14003

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14013

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 8600 16th Street	
3. NAME OF DECEASED (Type or print) WALTER First Middle Last		4. DATE OF DEATH Oct. 8 1967 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years birth day) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov.	
11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Arch		14. MOTHER'S MAIDEN NAME Maria Bojorie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Arch - 8600 16th St., Sil. Sp., Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Coronary Artery Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Read M.D.		22. DATE SIGNED Oct. 8, 1967	
EXAMINER'S NAME (Type) BELDEN R. READ M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 10/11/67		23c. NAME OF CEMETERY OR CREMATORY Glade cem.	
23d. LOCATION (City or Town) (County) (State) Walkersville Fred. Md.		24. FUNERAL DIRECTOR H. C. Barton ADDRESS Walkersville, Md.	
25a. REC'D BY REGISTRAR OCT 13 1967 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

14014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in lb <u>15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Squ. & Hospital</u>		d. STREET ADDRESS <u>8803 - 23rd Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Parke Alfred Arnold</u>		4. DATE OF DEATH Month <u>10</u> Day <u>-31-</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1902</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Govt Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Minnee Reeder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT (Mrs. Nellie Arnold) Address <u>wife 8803 - 23rd Ave Adelphi, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism R. lung.</u> DUE TO (b) <u>chronic phlebitis left leg -</u> DUE TO (c) <u>chronic nephrosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis & Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-10 minutes</u> <u>1 year</u> <u>3-4 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November, 1941</u> to <u>10/31/1967</u> , that (I) (we) last saw the deceased alive on <u>10-31-1967</u> , and that death occurred at <u>8:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>N.C. Shoemaker M.D.</u>		22b. DATE SIGNED <u>11-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>N.C. Shoemaker M.D.</u>		22d. ADDRESS <u>811 Dale Drive Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>The S. H. Hines Company - Washington, DC</u>		25a. REC'D BY REGISTRAR <u>NOV 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11011

THE STATE OF NEW YORK

11003

IN SENATE,
January 1, 1903.
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1902.
ALBANY:
J. B. LEECH, PRINTERS,
1903.

THE LAND OFFICE
OF THE STATE OF NEW YORK
HAS THE HONOR TO ACKNOWLEDGE
THE RECEIPT OF THE
REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1902.
JANUARY 1, 1903.

THE LAND OFFICE
OF THE STATE OF NEW YORK
HAS THE HONOR TO ACKNOWLEDGE
THE RECEIPT OF THE
REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1902.
JANUARY 1, 1903.

CERTIFICATE OF DEATH

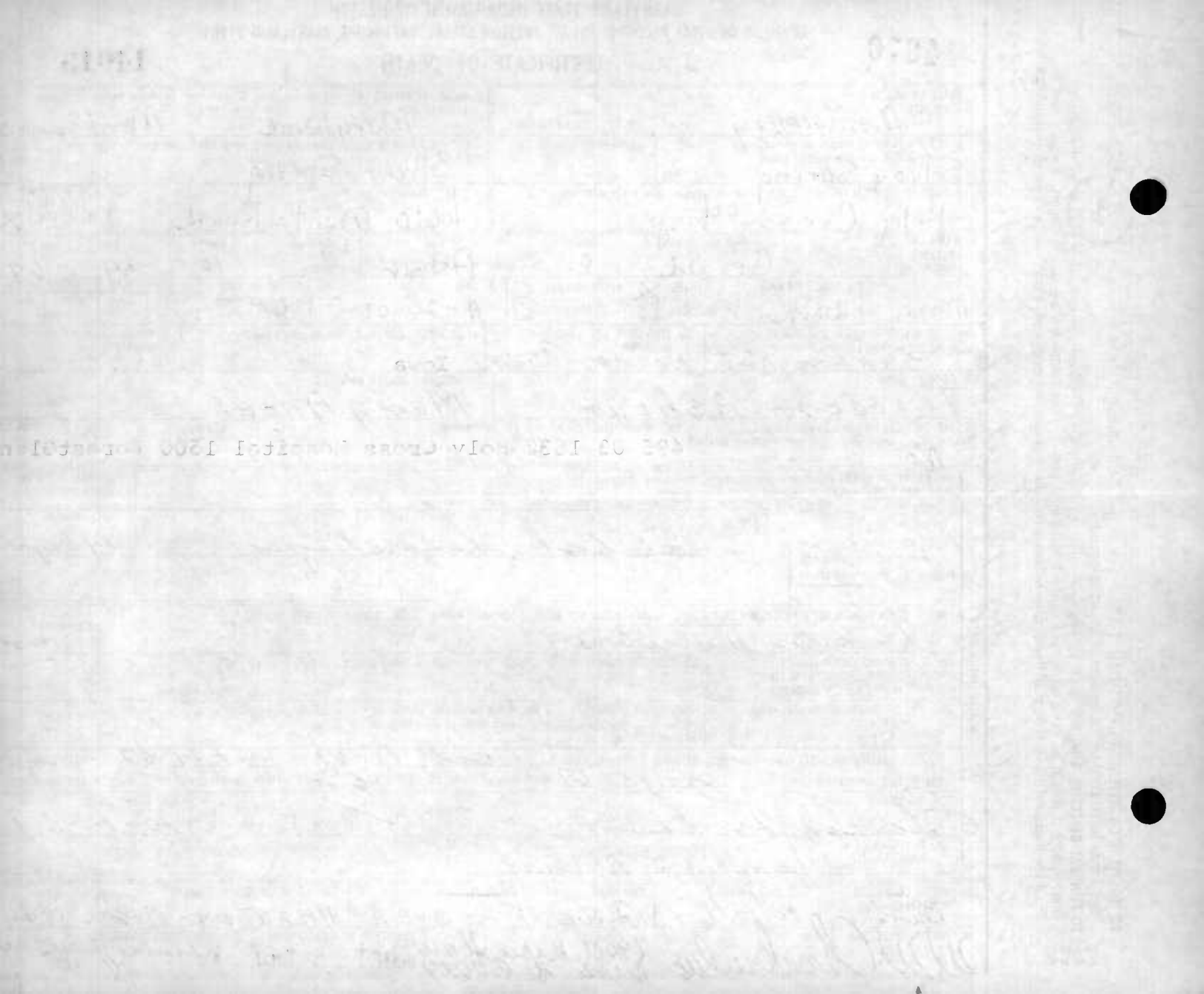
14010

14015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>151</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		d. STREET ADDRESS <u>10610 Mantz Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Gerald</u> Middle <u>E.</u> Last <u>Ashour</u>		4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-01</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber-Ret. Wendor Bread</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Ashour</u>		14. MOTHER'S MAIDEN NAME <u>Mary Angel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>495 03 1632</u>	
17. INFORMANT <u>Holy Cross Hospital</u>		Address <u>1500 Forest Glen Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>14 days</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1967</u> , to <u>Oct 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 13 1967</u> , and that death occurred at <u>6 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Richards</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-14-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Wheaton - Mont. Md.</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Inc.</u>		25a. REC'D BY REGISTRAR <u>1400 Capital St. NW</u> DATE <u>OCT 18 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

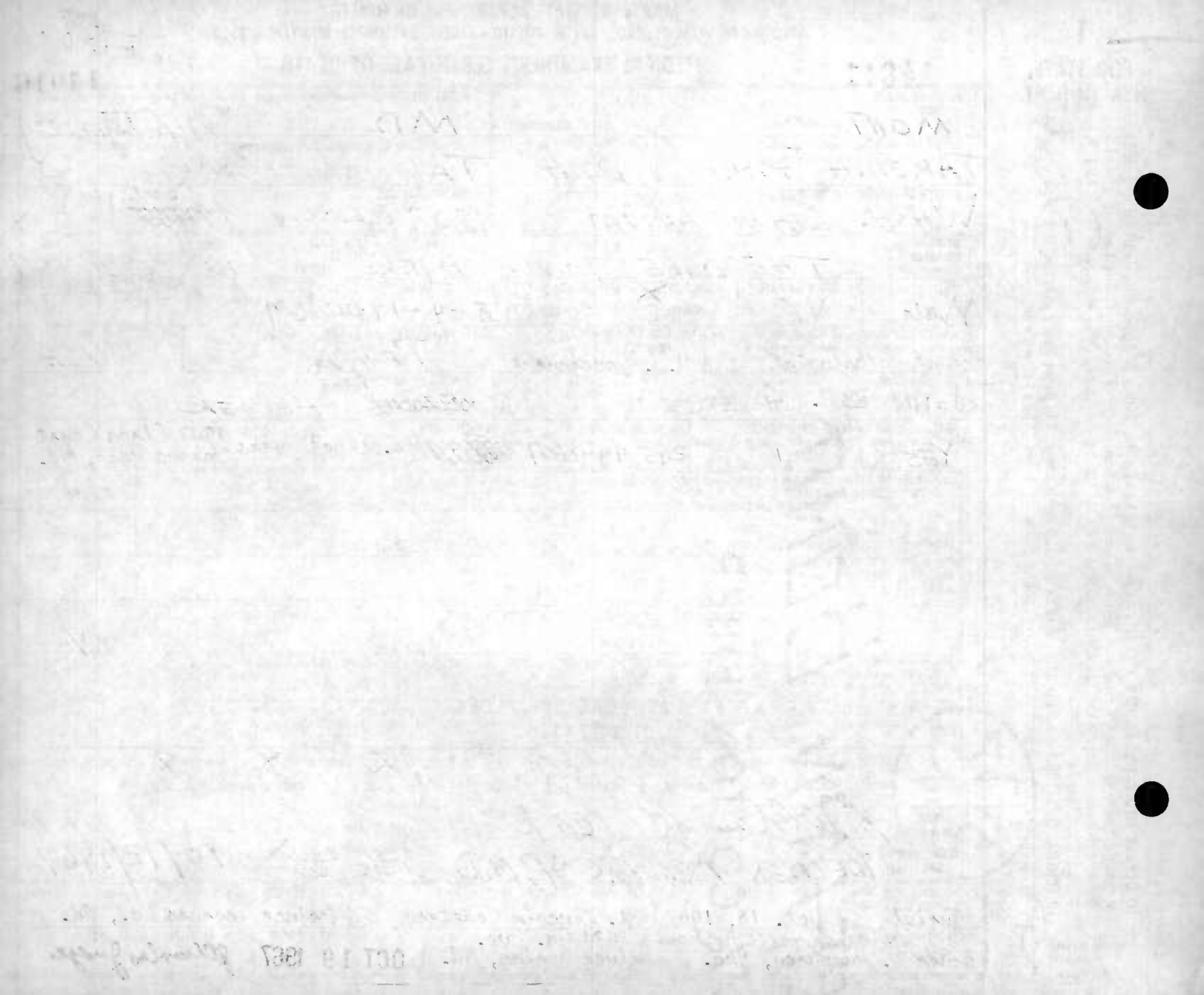
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

Items 18-21 Film #394
0-25-67 mt
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONT.gomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN TB <u>DO A.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		d. STREET ADDRESS <u>1303 ELSON COURT</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THEODORE THOMAS AYERS</u>		4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-4-1900</u>
9. AGE (In years last birthday) yrs. <u>67</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>13</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Pathologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOHN D.P. AYERS</u>		14. MOTHER'S MAIDEN NAME <u>HEIZER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>215-44-8267</u>	
17. INFORMANT <u>Mrs. Ethel Ayers</u>		Address <u>1303 Elson Court Takoma Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>10/13/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		Address (Street city, and county) <u>Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>ACT 19 1967</u>	
Address <u>1000 Ga. Ave. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

14017

14012

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 4 mos 23 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 4544 Harlow Blvd.	
3. NAME OF DECEASED (Type or print) First Betty Middle Faye Last BALLARD		4. DATE OF DEATH Month October Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1941
9. AGE (In years last birthday) 26 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H-Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Augustus Barker		14. MOTHER'S MAIDEN NAME Bessie Louise Waters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Panasoffke, Florida Mrs. Rufus Adams, P.O. Box 175, Lake			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE, CAROTID ARTERY, RIGHT DUE TO (b) RHABDOMYOSARCOMA, RIGHT TONSIL DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 24 , 19 67 , to Oct. 17 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 17 , 19 67 , and that death occurred at 4:15 PM , from causes and on the date stated above.			
22a. SIGNATURE G. W. Taylor		22b. DATE SIGNED Oct. 19, 1967	
22c. PHYSICIAN'S NAME (Type) G. W. TAYLOR, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/20/67	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) Jacksonville, Fla.
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N.W. Washington, D. C.		25a. REC'D BY REGISTRAR OCT 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1012

LETTER OF CREDIT

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NEW YORK

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VR A15 (4)
25M 1/67

14013				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14018			
CERTIFICATE OF DEATH				14018							
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>11 mos / 28 days / 16</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>8303 Navahoe Dr.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fra Russell Barden</u>				4. DATE OF DEATH Month Day Year <u>October 24, 1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-25-21</u>		9. AGE (In years last birthday) <u>46</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during the most of working life, even if retired) <u>Bricklayer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building Contrs.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jesse Barden</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Holiday</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes give year or dates of service) <u>No</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-5-2</u> , 19 <u>52</u> to <u>10-24</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-23</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> AM, from causes and on the date stated above.											
22a. SIGNATURE <u>M. Snow MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Oct. 24, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. Snow, MD.</u>				22d. ADDRESS <u>9013 Flower Avenue, Takoma Park, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Md.</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				24a. ADDRESS <u>8421 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>OCT 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>R Charles Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH
10-23-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14014

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14019

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 10 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL OF SILVER SPRING				d. STREET ADDRESS 824 8th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN		First Middle Last BARNES		4. DATE OF DEATH Month OCTOBER Day 8 Year 1967			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/5/38		9. AGE (In years lost birthday) 29 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME IRVING JOHNSON			14. MOTHER'S MAIDEN NAME PERGY BRYANT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT R.D. BLANKENSHIP - 824-8th St. Laurel, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute and old coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery heart disease, severe DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap			M.D.			22. DATE SIGNED OCT. 8, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.			DEPUTY MEDICAL EXAMINER Johnston (City or town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 11, 1967		23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		23d. LOCATION (City or Town) (County) (State) BURTONSVILLE MARYLAND	
24. FUNERAL DIRECTOR Johnston			25a. REC'D BY REGISTRAR LAUREL MD		25b. REGISTRAR'S SIGNATURE Johnston		

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
OFFICE OF THE SECRETARY
ATTENTION: ASSISTANT SECRETARY FOR
GENERAL AFFAIRS
FROM: [illegible]
SUBJECT: [illegible]

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15
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14015

CERTIFICATE OF DEATH

14020

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>12016 - Clarendon Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>T.</u> Last <u>Barrett</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/17</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert T. Barrett</u>		14. MOTHER'S MAIDEN NAME <u>Teresa C. Welsh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>yes. W.W.II</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Agnes E. Barrett</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis and thrombosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>9-24</u> , 19 <u>67</u> , to <u>10-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-2</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>W. F. Joyce</u>		22b. DATE SIGNED <u>10-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. F. JOYCE</u>		22d. ADDRESS <u>4977 Battery lane, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>F. J. Collins</u>		25a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
FRANCIS J. COLLINS 3821 14TH. ST. N.W.		DATE <u>OCT 5 1967</u>	

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CRITICAL OF HEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 393
10-20-67 ams
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #2c & d Film #G393 10/19/67 ph

14016

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14021

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNIVERSITY NURSING HOME Bethesda		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL			d. STREET ADDRESS 5300 Westbroad Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) HENRIETTA			4. DATE OF DEATH Oct. 7 19 67		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15, 1887		9. AGE (In years lost birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK, USA	
13. FATHER'S NAME Harris Cohen			14. MOTHER'S MAIDEN NAME Silvia		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Silvia Vogel- 1900 Lyttonsville Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 260x IMMEDIATE CAUSE (a) Bilateral lobar pneumonia, DUE TO (b) Coronary artery heart disease DUE TO (c) Diabetes Mellitus					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Read M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Oct. 7, 1967	
EXAMINER'S NAME (Type) BELDEN R. READ M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (State, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden Falls Church, Va.	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		25a. REC'D BY REGISTRAR Oct 11 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	
3501 14th. Street, N.W.; Wash., D.C.					

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MASSACHUSETTS

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WINTER HAVEN

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14017

14722

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 hrs. 3 min</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		d. STREET ADDRESS <u>Box 153</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Wilson Beall</u>		4. DATE OF DEATH <u>Oct. 11 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-42</u>
9. AGE (In years lost birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montgomery County Roads Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marion Wilson Beall</u>		14. MOTHER'S MAIDEN NAME <u>RUTHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>216-40-6191</u>	
17. INFORMANT <u>add same as address</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries, multiple and severe</u> DUE TO (b) <u>secondary to automobile accident</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car that crashed into utility pole</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-3-1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Neen Saana Montgomery Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		22. DATE SIGNED <u>10/11/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 13-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City or Town) (County) (State) <u>Beallville Montg Md</u>	
24. FUNERAL DIRECTOR <u>William B. Hilton, Barnesville</u>		25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>	
ADDRESS <u>Beallville</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

My dear Mr. [unclear]
I have just received your letter of the 10th inst. and am
glad to hear that you are well. I am
very much interested in the
progress of your work and hope
to hear from you again soon.
Yours very truly,
[unclear]

I am, Sir,
Very respectfully,
Your obedient servant,
[unclear]

CERTIFICATE OF DEATH

14018

14023

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Revised by Medical Examiner

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>10 A.</u>		d. STREET ADDRESS <u>205-71 Adams St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence Emily Beall</u>		4. DATE OF DEATH <u>Oct. 23 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/1882</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE W. YNGLESBEE</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE C. HEIMS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-7313</u>	
17. INFORMANT <u>Charles Judge</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>last</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7</u> , 19 <u>60</u> , to <u>23 Oct</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>19 Oct</u> , 19 <u>67</u> , and that death occurred at <u>11 A.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>W. S. Murphy</u>		22b. DATE SIGNED <u>10-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. S. Murphy</u>		22d. ADDRESS <u>615 W. Montgomery Ave. Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Goshen Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Goshen, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 26 1967</u>	

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RECEIVED

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Lodi, California

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14019

CERTIFICATE OF DEATH

14024

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16-2 d. STREET ADDRESS <u>2415 Chapman Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph Dalridge Beavers</u> First Middle Last			4. DATE OF DEATH <u>Oct. 2</u> 19 <u>67</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6 - 1920</u>	9. AGE (In years last birthday) <u>47</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elect. M.T.A.</u>		
10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>SAMUEL Beavers</u>			14. MOTHER'S MAIDEN NAME <u>Eva. Skinner</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Medical Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized carcinoma</u> DUE TO (c) <u>carcinoma colon</u>					INTERVAL BETWEEN ONSET AND DEATH <u>78 hours</u> <u>18 months</u> <u>4 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>10/2</u> , 19 <u>67</u> , that (I) (we) <u>we</u> saw the deceased alive on <u>10/2</u> 19 <u>67</u> , and that death occurred at <u>12⁵⁰</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>HUGH W. IREY</u>					22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>HUGH W. IREY</u>			22d. ADDRESS <u>7105 Riggs Rd. Hyattsville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery Prince Georges County, Md.</u>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <u>Mr. S.H. Hines & 2901-14th St. N.W.</u>			25a. REC'D BY REGISTRAR <u>OCT 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14020 CERTIFICATE OF DEATH 14025									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>✓</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>266 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sarasota</u> 483			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>					d. STREET ADDRESS <u>1424 4th Street</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Orville John Beemer</u>					4. DATE OF DEATH Month Day Year <u>October 9 1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11 August 1916</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Beemer</u>					14. MOTHER'S MAIDEN NAME <u>Lola Mae Biker</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>299-05-1602</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of Left Carotid Artery</u> DUE TO (b) <u>Recurrent Squamous Cell Carcinoma of Neck with</u> Erosion of Carotid Artery (c) <u>1 Year</u> Interval between onset and death <u>5 days</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan. 16, 1967</u> , to <u>Oct. 9, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct. 9, 1967</u> , and that death occurred at <u>11:45M</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>Jean B. de Kernion</u>					P.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>11 October 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jean B. de Kernion, M. D.</u>					22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Daunton</u>			23d. LOCATION (City or Town) (County) (State) <u>Maryland</u>		
24. FUNERAL DIRECTOR <u>Araguez</u>					ADDRESS <u>389 Rhode Island</u>		25a. REC'D BY REGISTRAR <u>OCT 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

14021

14026

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington DC	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 1717 Juniper St NW	
3. NAME OF DECEASED (Type or print) First Robert Middle Bengis Last Bengis		4. DATE OF DEATH Month 10 Day 8 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/1890
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chemist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CONNECTICUT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Bengis		14. MOTHER'S MAIDEN NAME Katherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. 049-01-4364	
17. INFORMANT Dorothy Bengis		Address Item # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED Oct. 8, 1967	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 10/9/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland Md.
24. FUNERAL DIRECTOR Joseph Gawler Sons Inc.		25a. REC'D BY REGISTRAR OCT 10 1967	
ADDRESS 5130 Wisconsin Ave NW Washington, D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1001

1001

Handwritten notes and signatures, including a large signature at the bottom right and a date stamp at the bottom left.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 5 min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		d. STREET ADDRESS 350 Cokeland St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jodi Middle Lynn Last Berger		4. DATE OF DEATH Month 10 Day 1 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1967
9. AGE (In years lost birthday) yrs. —		IF UNDER 1 YEAR Months — Days — Hours — Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Montgomery Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Eugene Berger		14. MOTHER'S MAIDEN NAME Patricia Ann Wess	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard Berger		Address Laurel, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7700 IMMEDIATE CAUSE (a) Hyphomys Foetalis DUE TO (b) Rh - HI Sanguitization DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE N. Stoehr		22b. DATE SIGNED 10-1-67	
22c. PHYSICIAN'S NAME (Type) N. Stoehr, M.D.,		22d. ADDRESS 831 University Blvd., E., Silver Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-2-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Washington San & Hospital		23d. LOCATION (City or Town) (County) (State) Takoma Park, Montg., Md.	
24. FUNERAL DIRECTOR J.D. Ruffcorn, 7609		ADDRESS Carroll Ave., Takoma Park, Md.	
25a. REC'D BY REGISTRAR 10-1-67		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Washington and Houston

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Oct. 1, 1933

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Washington Co., Maryland

Richard Eugene Berger

Richard Eugene Berger

Richard Eugene Berger, Maryland

W. Seeger, M.D.

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10-2-33

Washington and Houston

John A. Park, 320 Columbia St., Washington, D.C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14023

14028

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>20A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8516 Fox Run</u>	
3. NAME OF DECEASED (Type or print) <u>Julian Lawrence Bernstein</u>		4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18-1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DIR. OF EDUCATION</u>		9. AGE (In years lost birthday) <u>46</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRONICS ENGR.</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.C.</u>	
13. FATHER'S NAME <u>HERMAN BERNSTEIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>121-07-4661</u>	
17. INFORMANT <u>JOAN BERNSTEIN</u>		Address <u>(Same as 20b)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary arteriosclerosis with occlusion</u> (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Bell</u>		22. DATE SIGNED <u>10/4/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. AARAT Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>FARMINGDALE, L.I., N.Y.</u>
24. FUNERAL DIRECTOR <u>Guiding Hand Home</u>		25a. REC'D BY REGISTRAR <u>4217-9th St. NW</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>OCT 9 1967</u>	

11/18/78

REPORT OF SURVEY

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CERTIFICATE OF DEATH

14024

14029

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>9 days</u>				d. STREET ADDRESS <u>11919 Old Columbia Pike</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nsg Home 2101 Fairland Rd Silver Sp. Md 20904</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Virginia Berry</u>				4. DATE OF DEATH <u>10 29 1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>80 Oct 1888</u>	
9. AGE (in years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sup. housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>private home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Edgehill, Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wesley Berry</u>				14. MOTHER'S MAIDEN NAME <u>Dora Rollin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Yes</u>			
17. INFORMANT <u>Rose Latvia Adm - RN</u> Address <u>2101 Fairland Rd Sil. Sp - Md. 20904</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of ovary generalized</u> Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma pancreas</u> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Severe Arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/1/1967</u> to <u>10/29/1967</u> , that (I) (we) last saw the deceased alive on <u>10/29/1967</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J M Warren</u> M.D.				22b. DATE SIGNED <u>Oct. 29, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>J M Warren</u>				22d. ADDRESS <u>Laurel Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>1967</u> REGISTRAR'S SIGNATURE <u>John J. Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the federal director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11-21

[Faint, mostly illegible text, likely a continuation of a death record or form. Some words like "Name", "Age", "Sex", "Race", "Religion", "Marital Status", "Cause of Death", "Place of Death", "Date of Death", "Time of Death", "Signature", "Witness", "Registrar" are faintly visible.]

NOV 1 1961
[Faint text at the bottom of the page, possibly a date stamp or signature line.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

CLEARED WITH MEDICAL EXAMINER - *med*

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14025		CERTIFICATE OF DEATH	
1430			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b D. O. A.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		d. STREET ADDRESS 3515 Farthing Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VERNE Middle RUBEN Last BERTSCH		4. DATE OF DEATH Month Oct. Day 25 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/25
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrator		10b. KIND OF BUSINESS OR INDUSTRY Nat. Pk. Serv.	
11. BIRTHPLACE (County & State, or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Otto Bertsch		14. MOTHER'S MAIDEN NAME Edna Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 504-12-7938	
17. INFORMANT Barbara Bertsch		Address Wheaton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) arterio-sclerotic heart disease DUE TO (c) unmedicated		INTERVAL BETWEEN ONSET AND DEATH unmedicated	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (I) (his hospital) attended the deceased from July , 19 67 to 25 Oct , 19 67 , that (I) (we) last saw the deceased alive on July , 19 67 , and that death occurred at 5A M, from causes and on the date stated above.			
22a. SIGNATURE Paul J. Noone		22b. DATE SIGNED Oct. 25, 1967	
22c. PHYSICIAN'S NAME (Type) Paul J. Noone		22d. ADDRESS 5201 Randolph Rd., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/11	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Nat'l Cemetery		23d. LOCATION (City or town) (County) (State) Rockville, Md.	
24a. FUNERAL DIRECTOR C. Glen Carter		24b. ADDRESS Georgia Avenue	
24c. Warner E. Humphrey, Inc.		24d. Silver Spring, Md.	
25a. REC'D BY REGISTRAR OCT 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

14031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY in 1b 1 MO. 25 days				BETHESDA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS				d. STREET ADDRESS 5901 GREENTREE RD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JAMES Buckley BLACK				4. DATE OF DEATH Month 10 Day 2 Year 67			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-1884	
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
GREEN FIELD, IND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME DR. JAMES P. BLACK				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 354-18-5049			
17. INFORMANT wife Jean S. Black				Address Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO (b) Pulmonary insufficiency DUE TO (c) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov , 19 66 , to Oct 2 , 19 67 , that (I) (we) last saw the deceased alive on Sept 26 , 19 67 , and that death occurred at 2:30 P.M., from causes and on the date stated above.							
22a. SIGNATURE George H. Mitchell				22b. DATE SIGNED Oct 2, 1967			
22c. PHYSICIAN'S NAME (Type) GEORGE H. MITCHELL				22d. ADDRESS 11125 Rockville Pike Rockville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-5-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cem		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR OCT 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1-10-81

DEPT. OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14027

14032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WASHINGTON b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN Tb 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNIVERSITY NURSING HOME		d. STREET ADDRESS 1629 COLUMBIARD HWY	
3. NAME OF DECEASED (Type or print) SAMUEL (NO MIDDLE NAME) BLOCK		4. DATE OF DEATH Month 10/21 Day 19 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1883
9. AGE (In years lost birthday) 84 yrs.		IF UNDER 1 YEAR Months 10 Days 21 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUSINESSMAN		10b. KIND OF BUSINESS OR INDUSTRY POLAND	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 308-30-6874	
17. INFORMANT MRS RUTH FREY		Address 1629 Columbia Rd NW	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA DUE TO (b) 2001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 6 MONTH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/19, 1967 to 10/21, 1967 that (I) (we) last saw the deceased alive on 10/21, 1967 and that death occurred at 10:24 AM , from causes and on the date stated above.			
22a. SIGNATURE Walter E. Goozh, M.D.		22b. DATE SIGNED 10/21/67	
22c. PHYSICIAN'S NAME (Type) Walter E. Goozh, M.D.		22d. ADDRESS 2309 Shorefield Rd., Wheaton, Md.	
23a. BURIAL/CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT 22-1967	23c. NAME OF CEMETERY OR CREMATORY United Hebrew Cem.	23d. LOCATION (City or Town) (County) (State) Staten Island, N.Y.
24. FUNERAL DIRECTOR Bernard Nanyansky / Son - 3501-14th St NW		25a. REC'D BY REGISTRAR DATE OCT 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #11 infor. taken from birth cert.											
14028						14033					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San & Hospital						d. STREET ADDRESS 8510 Flower Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Baby Boy		Middle Bloomer		Last Bloomer		4. DATE OF DEATH Month October Day 18 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH October 18, 1967		9. AGE (In years lost birthday) — yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Takoma Park, Md.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Barry James Bloomer						14. MOTHER'S MAIDEN NAME Donna Juanita Brady					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Barry Bloomer, Takoma Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple abnormalities 7593 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) 31 wks. gestation										INTERVAL BETWEEN ONSET AND DEATH 48 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.											
22a. SIGNATURE Emma Hughes						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) E. Hughes, M.D.						22d. ADDRESS 831 University Blvd., E., Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10-19-67		23c. NAME OF CEMETERY OR CREMATORY Washington San & Hospital Takoma Park, Montg., Md.				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR J. Ruffcorn, 7600 Carroll Ave., Takoma Park, Md.						25a. ADDRESS 10-19-67		25b. SIGNATURE John Ruffcorn			

7-261906

1023

Washington

Telecom Park

Washington and Hospital

Baby Boy

White

Betty Jane Bloomer

Betty Bloomer, Telecom Park, Md.

Bloomer, Telecom Park

October 18, 1967

Black

8310 Telecom Ave.

Telecom Park

Washington

1023

Washington, D.C.

10-19-67

7600 Carroll Ave., Telecom Park, D.C. 10-19-67

Oct 19 1967

831 University Ave., D.C. 20001

Washington and Hospital, Telecom Park, D.C.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14034

14029

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6416 Shadow Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>FLEMING</u> Middle <u>B</u> Last <u>BOMAR</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-2-14</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>	
11. BIRTHPLACE (State or foreign country) <u>SPARTENBURG S. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HORACE BOMAR</u>		14. MOTHER'S MAIDEN NAME <u>MAULIE BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1941-1943</u>		16. SOCIAL SECURITY NO. <u>Doris Bomar</u>	
17. INFORMANT (wife) <u>Doris Bomar</u>		Address <u>6416 Shadow Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute Coronary thrombosis,, descending branch, left coronary</u> DUE TO (b) <u>Advanced Coronary arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED <u>10/24/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>10/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u> ADDRESS <u>5130 Wisconsin Avenue, N.W., Wash. D. C. 20016</u>		25a. REC'D BY REGISTRAR <u>OCT 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1508

Plumage

29

to the [illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]

500-9-100

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																								
14030																								
CERTIFICATE OF DEATH																								
Reg. Dist. No.																								
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 Upton Street</u>					d. STREET ADDRESS <u>207 Upton Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>ELIZABETH</u> Middle <u>BRIDGES</u> Last					4. DATE OF DEATH <u>October 15,</u> 19 <u>67</u> Month Day Year																			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1916</u>		9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Paris, Illinois</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>																
13. FATHER'S NAME <u>Karl F. Miller</u>					14. MOTHER'S MAIDEN NAME <u>Ethel Ogden</u>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>577-24-9881</u>		INFORMANT Address <u>Robert W. Bridges-Item # 2</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Lung metastases</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that, I attended the deceased from <u>May 1967</u> 19, to <u>10/15/67</u> , 19, that I last saw the deceased alive on <u>10/15/67</u> , 19, and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) DATE SIGNED <u>Henry C. Scruggs M.D. 5413 Cedar Lane 10/15/67</u>														
ACTUAL SIGNATURE <u>Henry C. Scruggs M.D.</u>										PHYSICIAN'S NAME (Type) <u>Henry C. Scruggs M.D. Bethesda Md</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>10/17/67</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>					22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>										ADDRESS <u>Funeral Home-1331 Rockville Pike Rockville, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>OCT 17 1967</u>					24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

NAME OF DECEASED _____
AGE _____ SEX _____
RACE _____
DATE OF DEATH _____
PLACE OF DEATH _____

CAUSE OF DEATH _____
MANNER OF DEATH _____

EDUCATION _____
OCCUPATION _____

RELIGION _____
MARRIAGE _____

PREVIOUS ILLNESS _____
TREATMENT _____

DATE OF BIRTH _____
PLACE OF BIRTH _____

DATE OF ENTRY INTO STATE _____
PLACE OF ENTRY INTO STATE _____

DATE OF ENTRY INTO CITY _____
PLACE OF ENTRY INTO CITY _____

DATE OF ENTRY INTO HOUSE _____
PLACE OF ENTRY INTO HOUSE _____

DATE OF ENTRY INTO ROOM _____
PLACE OF ENTRY INTO ROOM _____

DATE OF ENTRY INTO BED _____
PLACE OF ENTRY INTO BED _____

DATE OF ENTRY INTO CHAIR _____
PLACE OF ENTRY INTO CHAIR _____

DATE OF ENTRY INTO COFFIN _____
PLACE OF ENTRY INTO COFFIN _____

CERTIFICATE OF DEATH

14036

14031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner Dr. Bledyn G. Reak
 1000 York Ave. Baltimore, Md.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton			c. LENGTH OF STAY IN 1b 23 Mos. 19 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				d. STREET ADDRESS 717 Lowander Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Yette Brott				4. DATE OF DEATH Month Day Year October 19 19 67				
5. SEX Female		6. COLOR OR RACE Caus.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1890		
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Katz				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-01-8186		17. INFORMANT Harry Brott, Same as 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 4200 DUE TO with hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept. 13, 1967 to Oct 19, 1967 that (I) (we) saw the deceased alive on Sept 13, 1967 , and that death occurred at 2:00 PM , from causes on and the date stated above.								
22a. SIGNATURE B. P. Lafsky				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct 19, 1967		
22c. PHYSICIAN'S NAME (Type) B. P. Lafsky, M. D.				22d. ADDRESS 2025 I Street N. W. Washington, D. C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-22-1967		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery		23d. LOCATION (City or Town) (County) (State) Hyattsville, Md.		
24. FUNERAL DIRECTOR Frederick Funeral Home				ADDRESS 4217 9th St N.W.		25a. REC'D BY REGISTRAR OCT 24 1967		
				25b. REGISTRAR'S SIGNATURE Othman Judge				

2434-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14032

14037

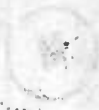
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN., + HOSPITAL				d. STREET ADDRESS 3330 Spencerville Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BETTY Middle MAE Last BROWN				4. DATE OF DEATH Month October Day 15 Year 1967			
5. SEX Fe	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/16/07	9. AGE (In years lost birthday) Yrs. 60	IF UNDER 1 YEAR Months 15 Days 15 Hours 67 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hswf		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas MARSHALL				14. MOTHER'S MAIDEN NAME MAGGIE MANESS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema (+atelectasis) DUE TO Congestive heart failure (b) arteriosclerotic heart disease DUE TO 3-4 days (c) 4200							INTERVAL BETWEEN ONSET AND DEATH 3-4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CVA / Uremia - polycystic + sclerotic kidney disease							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) this hospital attended the deceased from July , 1967, to Oct 15 , 1967, that (II) (we) last saw the deceased alive on Oct 15 , 1967, and that death occurred at 3:00 P. M, from causes on and on the date stated above.							
22a. SIGNATURE John R. Spencer				22b. DATE SIGNED 10-15-67		22c. PHYSICIAN'S NAME (Type) John R. Spencer	
22d. ADDRESS Takoma Pk Hospital, Takoma Pk. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-23-67	23c. NAME OF CEMETERY OR CREMATORY Goshen Cemetery		23d. LOCATION (City or Town) (County) (State) Church Hill, Tenn.			
24. FUNERAL DIRECTOR Francis H. Barber ADDRESS Laytonsville, Md.				25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

11037

INSTITUTE OF DEATH

11037



John R. Gannett, Jackson, Miss.

John R. Gannett

George Hill, Tenn.

George Hill, Tenn.

10-23-07

Revised

Lawrenceville, Mo.

Lawrenceville, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14033					14038				
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>2 1/2 Months</i>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Rockville 15-1</i> d. STREET ADDRESS <i>4811 Rockwood Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <i>Dorothea Anita Brown</i>					4. DATE OF DEATH Month Day Year <i>10 4 19 67</i>				
5. SEX <i>F</i>		6. COLOR OR RACE <i>Cas.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-24-1893</i>		9. AGE (In years last birthday) <i>73</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Musician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife Own Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Charles Schilling</i>					14. MOTHER'S MAIDEN NAME <i>Minnie ?</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>578-44-3956</i>				
17. INFORMANT <i>James R. Brown</i>					Address <i>4011 Blackpool Road Rockville, Maryland</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> 500X DUE TO (b) <i>Pneumonia - atelectasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Bronchitis - severe - acute</i> DUE TO (c) <i>92 hours</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary artery disease; Cong heart failure; Central vasc. insufficiency</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>Oct 4, 1967</i> , that (I) (we) last saw the deceased alive on <i>Oct 4 1967</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Thomas E. Curtin</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22b. DATE SIGNED <i>Oct. 4, 1967</i>									
22c. PHYSICIAN'S NAME (Type) <i>Thomas E. Curtin</i>					22d. ADDRESS <i>4600 Connecticut Ave. N.W. Wash D.C.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Oct. 7, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Snitland Maryland</i>		
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc.</i>					25a. REC'D BY REGISTRAR DATE <i>OCT 9 1967</i>				
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

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OCT 9 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14034

14039

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d. STREET ADDRESS <u>720 Beall Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Erma</u> Middle <u>L</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/23/84</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Laytonsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Gaither</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Layton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-07-0977A</u>	
17. INFORMANT <u>Mr. Charlie G. Brown Same as #2</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular thrombosis</u> DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-18</u> , 19 <u>67</u> , to <u>10-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-23</u> , 19 <u>67</u> , and that death occurred at <u>2:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>D. C. Bucy</u>		22b. DATE SIGNED <u>10-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. C. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Upperville Virginia</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
25a. REC'D BY REGISTRAR <u>OCT 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1-1030

1-1030

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Maryland

Rockville

750 Beall Ave.

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Home

R. Wife

George Calisher

Officer Layton

Mr. Charles D. Brown gave as 42

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Virginia

Upperville

IVY Hill

10-11-07

Barber

Frederick H. Barber, Daytonville, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY COUNTY				MONTGOMERY COUNTY			
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>15 1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>8408 GALVESTON ROAD</u>			
3. NAME OF DECEASED (Type or print) <u>REBECCA G. BRYAN</u>				4. DATE OF DEATH Month <u>10</u> - Day <u>21</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/85</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wren Wreckenson</u>				14. MOTHER'S MAIDEN NAME <u>Laura Gates</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>320-20-4360-A</u>		17. INFORMANT Address <u>Mrs. Phillip Mixsell 8408 Galveston Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Carcinoma, right breast</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>4 days</u> <u>10 MON.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemorrhage, Gastric</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> to <u>Oct 21</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Oct 21</u> 19 <u>67</u> , and that death occurred at <u>1:10 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>George B Patrick Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George B Patrick Jr</u>				22d. ADDRESS <u>9221 Collesville Rd Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Johnston City, Ill.</u>	
24. FUNERAL DIRECTOR <u>Glen Carter C. Warner E. Pumphrey Inc.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

REPORT OF THE

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14041

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 3 wks.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9807 Hillridge Dr., Kensington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARIE Atterbury Burkhard		4. DATE OF DEATH Month Oct. Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1884
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 13 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Atterbury		14. MOTHER'S MAIDEN NAME Jennie Woodward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Eleanor B. Steadman (above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Coronary arteriosclerotic heart disease DUE TO (c) 1 yr.			INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/23, 1967 to 10/13, 1967 , that (I) (we) last saw the deceased alive on 10/13, 1967 , and that death occurred at 9:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Joseph J. Wallace		22b. DATE SIGNED 10/13/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH J. WALLACE M.D.		22d. ADDRESS 5817 LENOX ROAD BETHESDA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 10-13-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Robert A. Humphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 16 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 1 1/2 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashton		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS New Hampshire Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna SNOWDEN First Middle Last		4. DATE OF DEATH Oct. 26 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-96
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Snowden		14. MOTHER'S MAIDEN NAME Frances Stabler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Montgomery General Hospital Address Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Unrecorded ischemic DUE TO (b) Rupture of aorta DUE TO (c) Abdominal aortic aneurism		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 hrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/26 1967 , to 10/26 1967 , that (I) (we) last saw the deceased alive on 10/26 1967 , and that death occurred at 5am M, from causes on and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10/26/67	
22c. PHYSICIAN'S NAME (Type) Dr. Charles Ligon		22d. ADDRESS Sandy Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10-26-67	
23c. NAME OF CEMETERY OR CREMATORY J. Wm. Lee Sons		23d. LOCATION (City or town) (County) (State) Mass. Ave. Washington, D.C.	
24. FUNERAL DIRECTOR Francis H. Barber Funeral Home ADDRESS Laytonsville Md.		25a. REC'D BY REGISTRAR OCT 30 1967 DATE	
25b. REGISTRAR'S SIGNATURE [Signature]			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G394 10/27/67 ph

CERTIFICATE OF DEATH

14038

14043

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>6 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Manor Nursing Home</u>		d. STREET ADDRESS <u>9101 Linton Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Lee</u> Last <u>Cage</u>		4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1883</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Michael Lee</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Miskell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-56-8974</u>	
17. INFORMANT <u>Mary C. Ryan</u>		Address <u>9101 Linton Street Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>20 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 10</u> , 19 <u>67</u> , to <u>OCT. 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>OCT. 17</u> , 19 <u>67</u> , and that death occurred at <u>4:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph V. Connor</u>		22b. DATE SIGNED <u>OCT. 17, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Connor</u>		22d. ADDRESS <u>9420 Old Georgetown Rd., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas Schnitzler</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>OCT 20 1967</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>	

1-10-13

RECEIVED

1000

1000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14044

14039

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> 15-1 d. STREET ADDRESS <u>6603 Hillandale Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rochiel Stewart Cameron</u> First Middle Last				4. DATE OF DEATH <u>10</u> Month <u>11</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 20 1899</u> 67	
9. AGE (In years lost birthday) yrs. <u>67</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Mgr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Joseph P. Cameron</u>			
14. MOTHER'S MAIDEN NAME <u>Caroline Babcock</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Frances Cameron</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>Several</u> years -			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				22. DATE SIGNED <u>10/11/67</u>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Mont. Co., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PITTSFIELD CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>PITTSFIELD, MASS.</u>	
24. FUNERAL DIRECTOR <u>JOS GAWLER'S SONS, 5130 WIS. AVE, NW, WASH., D.C.</u>				25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14040

CERTIFICATE OF DEATH

14045

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 3809 Elby St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA E. CAMPBELL				4. DATE OF DEATH Month Day Year OCT. 2 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1885	
9. AGE (In years lost birthday) yrs. 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Sharon, Vermont		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carlos Thurston				14. MOTHER'S MAIDEN NAME Emma Hunt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Doris Tritle - same above - daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Pyelonephritis and Bladder Cancer - P. 181.0 DUE TO (b) Left Pyelonephritis DUE TO (c) Cancer of the urinary bladder INTERVAL BETWEEN ONSET AND DEATH 1 month 6 months							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1 , 19 67 , to Oct 2 , 19 67 , that (I) was last saw the deceased alive on Oct 1 , 19 67 , and that death occurred at 12:00 AM , from causes and on the date stated above.							
22a. SIGNATURE Michael A. Dobridge				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct 3, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Michael R. Dobridge				22d. ADDRESS 12600 Parkland Drive, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/67		23c. NAME OF CEMETERY OR CREMATORY Leyden Cemetery		23d. LOCATION (City or Town) (County) (State) Springfield, Mass.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				25a. REC'D BY REGISTRAR DATE OCT 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1945

CHURCH OF BRANCH

1945

Handwritten notes and entries, mostly illegible due to fading and bleed-through. Some visible words include "CHURCH", "BRANCH", and "1945".

Large section of handwritten text, appearing to be a list or series of entries. The handwriting is cursive and mostly illegible.

Bottom section of handwritten text, including what appears to be a signature or name at the end of a line.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14041					14046						
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Opney</i> c. LENGTH OF STAY IN 1b <i>2 years</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Brand Grove Foundation</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> d. STREET ADDRESS <i>11704 Ashley Drive</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>MARGARET Louise Campbell</i>			First Middle Last		4. DATE OF DEATH <i>Oct. 24 1967</i>		Month Day Year		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 29, 1905</i>		9. AGE (In years last birthday) <i>62 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Washington D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edwin Sullivan</i>				14. MOTHER'S MAIDEN NAME <i>Neva Tice</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>W. Lawrence Haynes (same as #2.)</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive cardiac failure</i> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) <i>old & repeated cerebral vascular accidents - Generalized arteriosclerosis</i> OUE TO (c) <i>Extremes emaciation (Pseudo-bulbar palsy)</i>										INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i> <i>3+ yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>9-15, 1965</i> , to <i>10-24, 1967</i> , that (I) (we) last saw the deceased alive on <i>8-24 1967</i> , and that death occurred at <i>9:50 P.</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>John R. Spencer</i>						22b. DATE SIGNED <i>10-24-67</i>		22c. PHYSICIAN'S NAME (Type) <i>JOHN R. SPENCER</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Oct. 26, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Colmar Manor Md.</i>			
24. FUNERAL DIRECTOR <i>Arthur Walter</i>						25a. REC'D BY REGISTRAR <i>Charles Jones</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			

3404

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>81 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8700 Darnestown Road</u>		d. STREET ADDRESS <u>8700 Darnestown Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> <u>Harley</u> <u>Carter</u>		4. DATE OF DEATH <u>Oct</u> <u>19</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24 1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Cty. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry C. Harley</u>		14. MOTHER'S MAIDEN NAME <u>Anna McCormick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-33-2895</u>	
17. INFORMANT <u>Guy L. Carter</u>		Address <u>Husband</u> <u>8700 Darnestown Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4330</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arterial Sclerosis</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 19 65</u> to <u>October 19 67</u> that (I) (we) last saw the deceased alive on <u>Oct 19 1967</u> , and that death occurred on <u>Oct 19 1967</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Corinne Cooper</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>CORINNE COOPER</u>		22b. DATE SIGNED <u>10-19-67</u>	
22d. ADDRESS <u>104 S. Washington St. Rockville</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-23-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11017

EXHIBIT OF CASE

11017

Exhibit 11017

8700 S. Main Street

Exhibit 11017
Exhibit 11017
Exhibit 11017

Exhibit 11017

Exhibit 11017

10-22-87

ROBERT A. FARMER, Esq., Attorney at Law

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14043

CERTIFICATE OF DEATH

14048

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>65 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>1333 Childress Street, N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Galvin</u> Last <u>Carter, Jr.</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 October 1947</u>		9. AGE (In years lost birthday) <u>20 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raymond C. Carter, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Viola Traynham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-64-0810</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericardial effusion, bilateral pleural effusion</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> ot work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Aug. 17</u> , 19 <u>67</u> , to <u>Oct. 21</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Oct. 21</u> , 19 <u>67</u> , and that death occurred at <u>8:20 M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Michael Emmer</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> P.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>22 October 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Michael Emmer, M.D.</u>		22d. ADDRESS <u>Institutes of Health, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Landover, Md.</u>	
24. FUNERAL DIRECTOR <u>Fraziers</u> <u>389 R. I. Ave., N.W., Wash, D.C. 20001</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

11001

CERTIFICATE OF DEATH

10001

STATE OF NEW YORK

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City of ...

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14044			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>400-N. Washington St</u>	
3. NAME OF DECEASED (Type or print) <u>Thelma Eleanor Carter</u>		4. DATE OF DEATH <u>Oct. 24</u> 19 <u>67</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/25/16</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4222</u> IMMEDIATE CAUSE (a) <u>Myocarditis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>10/25/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		22. DATE SIGNED <u>10/25/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>COUNTY CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE, MD</u>	
24. FUNERAL DIRECTOR: <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>NOV 7 1967</u>	
ADDRESS <u>ROCKVILLE, MD</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1-10-12

UNITED STATES DEPARTMENT OF AGRICULTURE

RECEIVED

DEPT. OF AGRICULTURE
WASHINGTON, D. C.

RECEIVED
JAN 10 1912
DEPT. OF AGRICULTURE
WASHINGTON, D. C.

CERTIFICATE OF DEATH

14050

14045

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 257 Congressional Lane	
3. NAME OF DECEASED (Type or print) ELIZABETH M. CHAMBERLIN		4. DATE OF DEATH Month Oct. Day 2 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 57
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Walter L. Messer		14. MOTHER'S MAIDEN NAME Amelia McBride	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 077-07-2353	
17. INFORMANT Husband		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Behemism DUE TO (b) Stroke (Hypertension) DUE TO (c) Perforation of intestinal ulcer		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 12 hrs. 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Regional embolism -		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/2, 1963 to 10/2, 1967 that (I) (we) last saw the deceased alive on 10/4, 1967 and that death occurred at 12:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Stephen N. Jones		22b. DATE SIGNED 10/4/67	
22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES		22d. ADDRESS 809 Viers Mill Rd., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-6-67	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 9 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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THREAT OF DEATH

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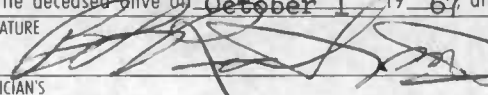
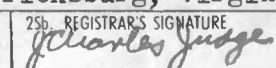
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14046

14051

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fredericksburg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN 1b 56 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fredericksburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 904 Sylvania Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Robert Welch COBLE, Jr.				4. DATE OF DEATH Month Oct. Day 1 Year 1967			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 8, 1946		9. AGE (In years lost birthday) yrs. 21		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps			10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Alexandria, Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert W. Coble				14. MOTHER'S MAIDEN NAME Doris J. Cato			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 9-9-66--10-1-67			16. SOCIAL SECURITY NO.		17. INFORMANT Fredericksburg Address Virginia Mr. Robert W. Coble, 904 Sylvania Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 193.9 Glioblastoma Multiforme IMMEDIATE CAUSE (a) 193.9 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Aug 6 , 19 67 , to Oct. 1 , 19 67 that (1) (we) last saw the deceased alive on October 1 , 19 67 and that death occurred at 530P PM, from causes and on the date stated above.							
22a. SIGNATURE 				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Oct. 3, 1967	
22c. PHYSICIAN'S NAME (Type) B. L. Rish, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/67		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Fredericksburg, Virginia	
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 West Broad Street, Falls Church, Virginia				25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE 	

11031

STATE OF DEATH

Virginia

Montgomery

Beltsville (rural)

30 days

Fredericksburg

1000 E. 1st Ave.

1000 E. 1st Ave.

Robert

Robert

COOK, R.

Oct.

Sept. 1, 1966

Sept.

Male

VA

Alexandria, Virginia

U. S. Marine Corps

Robert W. Cook

Robert W. Cook

Fredericksburg, Virginia

Mr. Robert W. Cook, 1000 E. 1st Ave.

Yes

Beltsville, Maryland

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14047

CERTIFICATE OF DEATH

14052

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
c. LENGTH OF STAY IN lb years		d. STREET ADDRESS 312 Baltimore Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 312 Baltimore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle LEE Last COLLIER		4. DATE OF DEATH Month Oct. Day 28, Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1912
9. AGE (In years last birthday) yrs. 55		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.E. Co. - Supervisor		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (County & State, or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Walter Lee Collier		14. MOTHER'S MAIDEN NAME Lula Ballenger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 577-050073	
17. INFORMANT wife		Address Capitola E. Collier Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung, with generalized 163X DUE TO bone metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (Collet study, no surgery except biopsy) DUE TO (c) (Collet study, no surgery except biopsy)			INTERVAL BETWEEN ONSET AND DEATH 8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 1967, to Oct 28 , 1967, that (I) (we) last saw the deceased alive on October 28 , 1967, and that death occurred at 6 A M, from causes and on the date stated above.			
22a. SIGNATURE W. A. Linthicum		22b. DATE SIGNED 10/28/67	
22c. PHYSICIAN'S NAME (Type) W. A. Linthicum, M.D.		22d. ADDRESS 110 S. Washington St - Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-30-67	23c. NAME OF CEMETERY OR CREMATORY Darnestown Cemetery	23d. LOCATION (City or Town) (County) (State) Darnestown, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE NOV 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF DEATH

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11-06-67 amS DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14048

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14053

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> LENGTH OF STAY IN 1b <u>15.1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>710 Dartmouth St.</u>		d. STREET ADDRESS <u>710 Dartmouth St.</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Colliere</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 March 1897</u>
9. AGE (In years lost, birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Newbrighton, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Bette Lindsay</u> Address <u>3501 Stark Street Kensington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive, Acute intracerebral</u> <u>331X</u> DUE TO hemorrhage, left cerebral hemisphere Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belolen R. Keap</u> M.D.		22. DATE SIGNED <u>10/23/1967</u>	
EXAMINER'S NAME (Type) <u>BELOEN R. KEAP, M.D.</u>		Address (City, town, or county) <u>Prince Georges Co. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Oct 26 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u> ADDRESS <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Clark E. Wisor</u>		DATE <u>OCT 30 1967</u>	

11003

RECEIVED

11003

THE NATIONAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]

[illegible text]

[illegible text]

10/11/60
[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

ANNAPOLIS STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14049

CERTIFICATE OF DEATH

14054

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		d. STREET ADDRESS <u>3414 Turner Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Althea Woodland Nursing Home, 1000 Daleview Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Wilson</u> Last <u>Comyn</u>		4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/1879</u>
9. AGE (In years lost birthday) yrs. <u>88</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>18</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Newcastle, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Dodd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>047-26-6142</u>	
17. INFORMANT <u>Mr Raymond H. Comyn</u>		Address <u>3414 Turner Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO <u>Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> to <u>Oct 18</u> , 19 <u>67</u> , that (H) (we) last saw the deceased alive on <u>10-18</u> , 19 <u>67</u> , and that death occurred at <u>10:20 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>10-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 UNIV. BLVD E, S.L. SP., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Adelphi, Maryland</u>
24. FUNERAL DIRECTOR <u>Watner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11004

CLINICAL OF EYE

11004

047-28-0125 Mr. Raymond H. Gorman, 11004
Hospice Dept.
Hospice, Oxford
Female white
✓ 2800000
Gorman
This is a photograph of the patient's eye.
The patient is a white female.
The patient is 28 years old.
The patient is a patient of the
Hospice, Oxford.
The patient is a patient of the
Hospice, Oxford.

047-28-0125 Mr. Raymond H. Gorman, 11004
Hospice Dept.
Hospice, Oxford
Female white
✓ 2800000
Gorman
This is a photograph of the patient's eye.
The patient is a white female.
The patient is 28 years old.
The patient is a patient of the
Hospice, Oxford.
The patient is a patient of the
Hospice, Oxford.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14055

14050

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5106 Brookview Dr.</u>			d. STREET ADDRESS <u>8012 old Georgetown Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>George. Thomas Coogan</u>			4. DATE OF DEATH Month <u>Oct</u> - Day <u>5</u> Year <u>1967</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/1939</u>	9. AGE (In years lost birthday) <u>28</u> yrs.	IF UNDER 1 YEAR Months <u>28</u> Days <u>28</u> Hours <u>28</u> Min. <u>28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CHICAGO, ILLINOIS</u>	
13. FATHER'S NAME <u>John T. Coogan.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			14. MOTHER'S MAIDEN NAME <u>MARIE PEDERSEN</u>		16. SOCIAL SECURITY NO.
17. INFORMANT <u>Father John T. Coogan</u>			Address <u>401 Ascot Drive Park Ridge, Ill.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by Hanging</u> DUE TO (b) <u>974X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>974X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self with garden hose -</u>			
20c. TIME OF INJURY Month, Day, Year <u>12 p.m. Oct 5 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Yard.</u>	
20f. (City or town) <u>Bethesda</u>		(County) <u>Montgomery</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John G. Ball</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/5/67</u>		
			Address (Street, city, town, or county) <u>Bethesda, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Emblem Cemetery</u>	
23d. LOCATION (City or Town) <u>Elmhurst, Illinois</u>		(County)		(State)	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>			25a. REC'D BY REGISTRAR DATE <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner/

Ernest E. Harmon

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14051

CERTIFICATE OF DEATH

14056

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MD.		c. LENGTH OF STAY IN 1b TAKOMA PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		d. STREET ADDRESS 22 PHILADELPHIA AVE	
3. NAME OF DECEASED (Type or print) HELEN GRANDFIELD COOK		4. DATE OF DEATH Month 10 Day 21 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-93
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 10 Days 21 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES PAXTON GRANDFIELD		14. MOTHER'S MAIDEN NAME JENNY MCKEE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT GEORGE A. COOK JR.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis DUE TO myocardial infarction & congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized atherosclerotic cardiovascular disease (c) Diabetes mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (U) (this hospital) attended the deceased from July , 1967, to Oct 21 , 1967, that (U) (two) last saw the deceased alive on 21 Oct 1967, and that death occurred at 8:20 PM from causes and on the date stated above.			
22a. SIGNATURE Ernest E. Harmon		22b. DATE SIGNED 21 Oct 67	
22c. PHYSICIAN'S NAME (Type) Ernest E. Harmon MD		22d. ADDRESS 7501 Colasville Rd S.W. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Oct. 24-1967	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery	23d. LOCATION (City or Town) (County) (State) Exeter Rd. Prince Georges Co. Md.
24. FUNERAL DIRECTOR Takoma Funeral Home		25. REC'D BY REGISTRAR 254 Carroll Ave NW	
25a. DATE OCT 24 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

Transcript

Continued from page 1

Diabetes mellitus

James E. Shannon

General and special
physical examination
and laboratory
investigation
showed no
evidence of
diabetes mellitus.

Very truly yours,
J. E. Shannon

First E. Shannon and 2201 Lusk Ave.
St. Louis, Mo.
Date: 1-10-20

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14052

14057

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN lb <i>25 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac Md & Chevy Chase Md</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>1100 3rd St NE</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Georgette B Carlin</i>		4. DATE OF DEATH <i>Oct. 19 19 67</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/21/01</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Housewife</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>France</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Bigot</i>		14. MOTHER'S MAIDEN NAME <i>Eugenie Edin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215-38-3743A</i>	
17. INFORMANT <i>George F. Carlin</i>		Address <i>Potomac Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer</i> DUE TO <i>Metastatic</i> (b) <i>adenocarcinoma of the colon</i> DUE TO <i>of the colon</i> (c) <i>last</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 18</i> , 19 <i>67</i> , to <i>Oct 19</i> , 19 <i>67</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>Oct 18</i> , 19 <i>67</i> , and that death occurred at <i>10:20</i> M, from causes on the date stated above.			
22a. SIGNATURE <i>Allen J. Neill</i>		22b. DATE SIGNED <i>10-20-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill MD</i>		22d. ADDRESS <i>8601 old Georgetown Rd Bethesda Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10-23-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>	23d. LOCATION (City or town) (County) (State) <i>Silver Spring, Maryland</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>Charles J...</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>OCT 25 1967</i>	

10-21-83

Thank you very much
for the money

Received from
Mother's money

James M. M.
X
2/21/81

1100 3/21/81
2/21/81

212-38-3144

10-21-83

Richard A. Murphy, Nevada, no bond
10-21-83
10-21-83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14053			
CERTIFICATE OF DEATH			
14058			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5 years 11 mos</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Althea Woodland Nursing Home, 1000 Daleview Dr.</u>		d. STREET ADDRESS <u>6424 Brookside Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha Maye Cornick</u>		4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-1886</u> 9. AGE (In years lost birthday) yrs. <u>81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Ashba</u>		14. MOTHER'S MAIDEN NAME <u>Ida Owens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mrs R.W. Markley, 6424 Brookside Dr. Cherry Chase, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>			
DUE TO (b) <u>Arterio-sclerotic heart disease</u>			
DUE TO (c) <u>Arterio-sclerosis generalized</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arterio-sclerosis - & Senility</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>67</u> , to <u>10-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 27</u> , 19 <u>67</u> , and that death occurred at <u>1:25 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Frederic J. Chapman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederic J. Chapman</u> <u>1234-19th St. NW</u>		22d. ADDRESS <u>1234-19th St. NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glendale, California</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>NOV 2 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14054		MONTGOMERY STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14059	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>521 Montgomery House</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Otha</u> First <u>NMN</u> Middle <u>Ceismond</u> Last		4. DATE OF DEATH <u>10-15</u> 19 <u>67</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-91</u> 76 yrs.	9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Machinist Fed. Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1949-1955</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>unknown</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>678-05-3118</u>		17. INFORMANT <u>Wife-Mable</u> Address <u>- Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> <u>Infarction, multiple, cerebral</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>10-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-19</u> 19 <u>62</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>D. C. Bucky</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. C. Bucky</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>	
				23d. LOCATION (City or Town) (County) (State) <u>Damascus, Md.</u>	
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>OCT 18 1967</u> DATE	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10054

14003

DEPARTMENT OF DEFENSE

Montgomery

and

Montgomery

Jefferson

Jefferson

Jefferson

Office

General

10-15

7-27-41

Mr. J. M.

Return - Robert R. Wright, Virginia

Wife - Noble - Jones

Mr.

Oct 18 1941

Oct 18 1941

10054

DEPARTMENT OF DEFENSE

14003

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (P)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14055

14060

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b WHEATON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		e. STREET ADDRESS 11311 Viers Mill Rd.	
3. NAME OF DECEASED (Type or print) First LEWIS Middle E Last CRIST		4. DATE OF DEATH Month OCTOBER Day 21 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/11
9. AGE (In years lost birthday) yrs. 56		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superv. Elect. Shop/		10b. KIND OF BUSINESS OR INDUSTRY N.O.L.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard Preston Crist		14. MOTHER'S MAIDEN NAME Myrtie Breedlove Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 216-18-6240	
17. INFORMANT Wife Ella L. Crist		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Conflagration DUE TO burns of 75% of Body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Surface. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased burned in arc type short circuit fire at work	
20c. TIME OF INJURY Month, Day, Year 12:30 a.m. 10-15-67		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) N.O.L. Bldg Silver Spring, Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		22. DATE SIGNED 10/21/1967	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		Address (If not in same county) Wheaton	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-25-67	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

14050

6555

MONTGOMERY

MONTGOMERY

MONTGOMERY COUNTY

WHEATON

Silver Spring

11311 Wheat Mill Rd.

HOLY CROSS HOSPITAL

OCTOBER 21 1961

LEWIS

3/15/11

MARYLAND

Superv. Elect. Shop, N.O.B.

State Executive Building

Howard Preston Office

Wife

11-11-6200 1111 N. 11th

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10-22-61

OCT 22 1961

10-22-61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14056

14061

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Loudoun		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 50 days		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chantilly		833		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS Route 1, Box 167		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Vivian Gladys Cross		4. DATE OF DEATH Month Day Year October 2 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 October 1913	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff		10b. KIND OF BUSINESS OR INDUSTRY Government		
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Cassius Downs		14. MOTHER'S MAIDEN NAME Nellie Rice		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		
17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminated pelvic carcinoma</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from August 13, 19 67, to October 2, 19 67 that (A) (we) last saw the deceased alive on October 2, 19 67, and that death occurred at 4:25 M, from causes and on the date stated above.				
22a. SIGNATURE Kenneth P. Ramming		22b. DATE SIGNED P.M. Oct. 2, 1967		
22c. PHYSICIAN'S NAME (Type) Kenneth P. Ramming, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/5/67	23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove	23d. LOCATION (City or Town) (County) (State) Herndon Fairfax Va.	
24. FUNERAL DIRECTOR Muse & Reed, Inc. Leesburg, Va.		25a. REC'D BY REGISTRAR OCT 5 1967		
25b. REGISTRAR'S SIGNATURE Charles Judge				

1205.1

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7/11/02

over the past 10 years.

1. The first step is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY COUNTY, MARYLAND				MONTGOMERY COUNTY, MARYLAND			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
5. SEX				6. COLOR OR RACE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				B. DATE OF BIRTH			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebrovascular accident DUE TO (b) Thrombosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				INTERVAL BETWEEN ONSET AND DEATH 4 days 2 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1960, to Oct 14, 1967, that (I) (we) last saw the deceased alive on 12:25 PM 19, and that death occurred at 12:35 PM, from causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			
MONTGOMERY MARYLAND				Md. Mont.			
Bethesda 15 days				Chevy Chase 15-1			
Suburban				1 Primrose St.			
Thomas LEONARD Cullinan				10-14 1967			
M				6. COLOR OR RACE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				B. DATE OF BIRTH			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
Retired - Dep. of Agriculture				West Virginia U.S.A.			
James CULLINAN				Annie WEBER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
No				Mrs. Enright - Sister - Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebrovascular accident DUE TO (b) Thrombosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				INTERVAL BETWEEN ONSET AND DEATH 4 days 2 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1960, to Oct 14, 1967, that (I) (we) last saw the deceased alive on 12:25 PM 19, and that death occurred at 12:35 PM, from causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
J. E. EVERETT M.D.				10/14/67			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
J. E. EVERETT				7400 Conn. Ave. Kensington, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
BURIAL				10/17/67			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
M.T. OLIVET CEM.				WASHINGTON, D.C.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR			
DR. GAULDER'S SONS, WASHINGTON, D.C.				OCT 18 1967			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			
Charles Judge				Charles Judge			

00 18 1963 1324 34 130

14058

CERTIFICATE OF DEATH

14063

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>11 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>5006 Baltic Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Therese</u> Middle <u>Marie</u> Last <u>Danaher</u>		4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years lost birthday) yrs. <u>1</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>19</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Silver Spring, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gerard Joseph Danaher</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Horman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Caroline Danaher</u> Address <u>5006 Baltic Avenue</u>		<u>Rockville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7543 Congenital heart disease, manifest by</u> DUE TO (b) <u>1. Mitral atresia</u> DUE TO (c) <u>2. Premature closure of foramen ovale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-5</u> , 19 <u>67</u> , to <u>10-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-4</u> , 19 <u>67</u> , and that death occurred at <u>5:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>George R. Spence</u> M.D.		22b. DATE SIGNED <u>10/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George R. Spence</u>		22d. ADDRESS <u>1515 Highland Drive Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>J. B. Thomas</u> ADDRESS <u>8434 Georgia Ave.</u>		25a. REC'D BY REGISTRAR <u>Warner E. Humphrey, Inc.</u> DATE <u>OCT 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10001

STATE OF TEXAS

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14064

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>1/2 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4607 Overbrook Rd.</u>		d. STREET ADDRESS <u>708 Anneslie Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Winnett</u> First <u>Shepherd</u> Middle <u>Dashie</u> Last		4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1902</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Dashnell</u>		14. MOTHER'S MAIDEN NAME <u>Edna Shepherd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-44-6442</u>	
17. INFORMANT <u>Freda Mithel Dashnell</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown In-sufficiency acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>7936 Georgetown Rd Bethesda Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/1/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	23d. LOCATION (City or town) (County) (State) <u>Pikesville, Balto. Co. Md.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>		25. REC'D BY REGISTRAR <u>OCT 30 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14050

14065

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmville</u>	
c. LENGTH OF STAY IN 1b <u>6 hrs</u>		d. STREET ADDRESS <u>1015 Northstone St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bobby Earl Davis</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1967</u>	
First Middle Last		Month Day Year	
5. SEX <u>F</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-67</u>	
9. AGE (In years last birthday) <u>26 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lee Orley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Theodore Davis</u>		Address <u>Home as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.N.S. Damage</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7:30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Frank Mate Jr.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10/5/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda Montg. MD</u>	
24. FUNERAL DIRECTOR <u>Mrs. Anelia C. Carter, Administrator</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 10 1967</u>	

7-264912

CERTIFICATE OF DEATH

14066

14061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural c. LENGTH OF STAY IN TB 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital, Bethesda, Maryland				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 5800 N. Flaxton Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Milton Howard DAVIS			4. DATE OF DEATH Month Day Year October 28 1967				
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 October 1893	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY Musician		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Edward Thomas DAVIS				
14. MOTHER'S MAIDEN NAME Margaret BURKHARDT			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1				
16. SOCIAL SECURITY NO. 579-07-5720			17. INFORMANT Ruth V. DAVIS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Brochopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerotic Vascular Disease with Severe Arteriolonephrosclerosis and DUE TO (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from 27 October, 1967 , to 28 October, 1967 , that (X) (we) last saw the deceased alive on 28 October 1967 , and that death occurred at 2:35 P.M. , from causes and on the date stated above.							
22a. SIGNATURE <i>David R. Foreman</i>				22b. DATE SIGNED 28 October 1967			
22c. PHYSICIAN'S NAME (Type) David R. FOREMAN LT MC USN				22d. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-31-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
23d. LOCATION (City or Town) (County) (State) Washington		23e. REC'D BY REGISTRAR NOV 1 1967					
23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		23g. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
24. FUNERAL DIRECTOR Demaine Funeral Home Alexandria, Virginia							

1961

1-10-61

STATE OF TEXAS

County of

City of

I, J. J. [Name], being of legal age, hereby certify that the following is a true and correct copy of the [document]

Witness my hand and seal this [day] of [Month], 1961.

Notary Public for the State of Texas

My commission expires on [date]

Subscribed and sworn to before me this [day] of [Month], 1961.

Notary Public for the State of Texas

My commission expires on [date]

Notary Public for the State of Texas

My commission expires on [date]

Subscribed and sworn to before me this [day] of [Month], 1961.

Notary Public for the State of Texas

My commission expires on [date]

Witness my hand and seal this [day] of [Month], 1961.

Notary Public for the State of Texas

My commission expires on [date]

Notary Public for the State of Texas

My commission expires on [date]

Notary Public for the State of Texas

My commission expires on [date]

Notary Public for the State of Texas

My commission expires on [date]

Notary Public for the State of Texas

My commission expires on [date]

Notary Public for the State of Texas

My commission expires on [date]

Notary Public for the State of Texas

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20M 1/65

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14067

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>620 Saint Andrews Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CHRISTINA</u> Last <u>DE NEANE</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 1, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	9. AGE (In years last birthday) <u>80</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Hoek</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>F. Edwin De Neane, 207 Indian St. S.E. Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular Renal Disease</u> 5715 (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u> </u> , to <u>Oct. 26</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/10</u> 19 <u>67</u> , and that death occurred at <u>6 A</u> .M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold Heiges</u>		22b. DATE SIGNED <u>10/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold Heiges</u>		22d. ADDRESS <u>5415 Conn. Ave NW DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters, 254 Carroll St NW, Wash DC</u>		25. REC'D BY REGISTRAR <u>OCT 27 1967</u>	
25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		26. REGISTRAR'S SIGNATURE	

11087

11087

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14063		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14068	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Geo.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENBELT</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp</u>			d. STREET ADDRESS <u>710 GREENBELT Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>LEE</u> Last <u>DENT</u>			4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-92</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Robert DENT</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-10-5948</u>		17. INFORMANT <u>Mrs Mary E. Brown</u> <u>903 Seeks Lane, Silver Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Prostate with</u> DUE TO (c) <u>Widespread Bone metastases</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchopneumonia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>67</u> , to <u>10/18/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u>1:25 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Joseph E. Smith, Jr. M.D.</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/</u>
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>			22d. ADDRESS <u>4140 Sandy Spring Rd., Burtonsville, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> <u>Rockville, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>OCT 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1962

UNITED STATES OF AMERICA

1962



UNITED STATES OF AMERICA

CERTIFICATE OF DEATH

14069

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. STREET ADDRESS <u>809 Hobbs Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>James</u> Last <u>Dillon, Jr.</u>		4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 April 1924</u> yrs. <u>43</u>
9. AGE (In years lost birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>	11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frank J. Dillon, Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Thelma Ray</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>236-28-9967</u>		17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (R. Lung)</u> DUE TO (b) <u>Acute Lymphocytic Leukemia</u> OUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>8 Months</u>	
PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>2 October, 1967</u> to <u>14 October 1967</u> , that <u>X</u> (we) last saw the deceased alive on <u>14 October 1967</u> , and that death occurred at <u>8:55 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John W. Keyes, Jr.</u>		22b. DATE SIGNED <u>15 October 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>John W. Keyes, Jr., MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>Oct. 19, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Millersville Memorial Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Millersville, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14065

14070

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>Washington D.C.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>4815 Illinois Ave. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Adams Dills</u> First Middle Last 4. DATE OF DEATH <u>10 13 1967</u> Month Day Year		5. SEX <u>m</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-26-95</u> 9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't worker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>		13. FATHER'S NAME <u>Samuel R Dills</u> 14. MOTHER'S MAIDEN NAME <u>Eva Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI-Army</u> 16. SOCIAL SECURITY NO. <u>579-50-254</u> 17. INFORMANT <u>BA Patient's Chart</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Congestive Heart Failure</u> DUE TO (b) <u>Coronary Occlusion and Myocardial</u> DUE TO <u>Interction both old and recent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Early Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>66</u> , to <u>October 13</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>October 13</u> , 19 <u>67</u> , and that death occurred at <u>2:39 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Stuart L. Nelson</u> 22c. PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>10-14-67</u> 22d. ADDRESS <u>7600 Carroll Ave. Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> 23b. DATE THEREOF <u>10/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Indian Orchard Cem.</u> 23d. LOCATION (City or Town) (County) (State) <u>Honesdale, Pa.</u>	
24. FUNERAL DIRECTOR <u>Free S. H. Hines</u> ADDRESS <u>2901-14th</u>		25a. REC'D BY REGISTRAR <u>OCT 17 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Geo</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN lb <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>16-2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Jan. & Hosp</u>					d. STREET ADDRESS <u>2215 Beechwood Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Wilson</u> Middle <u>None</u> Last <u>DISNEY</u>					4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-20-00</u>		9. AGE (In years last birthday) <u>67</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Company</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thales Disney</u>					14. MOTHER'S MAIDEN NAME <u>Virginia Turner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>577-05-7940</u>		17. INFORMANT <u>Chart</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>9-20</u> , 19 <u>67</u> , to <u>10-16</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>10-15</u> , 19 <u>67</u> , and that death occurred at <u>1:30 PM</u> , from causes on and on the date stated above.										
22a. SIGNATURE <u>W.B. Wardrop MD</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>10-17-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>W.B. WARDROP MD</u>					22d. ADDRESS <u>808 PERSHING Dr. Silver Spring Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Francis Saccis Sons</u>					ADDRESS <u>Hyattsville, Md</u>		25a. REC'D BY REGISTRAR <u>OCT 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14001

3403

CERTIFICATE OF DEATH

THE STATE OF NEW YORK
COUNTY OF [illegible]

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]

Witness my hand and seal

this 1st day of [illegible] 19[illegible]

Notary Public

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14067

14072

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		MARYLAND c. LENGTH OF STAY IN 1b <u>20 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4607 Edgewood Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gertrude Dacey</u>		First <u>Dacey</u> Middle <u>Doherty</u> Last <u>Doherty</u>		DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/99</u>		9. AGE (In years last birthday) yrs. <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>John C. Dacey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Doyle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-56-4878</u>		17. INFORMANT <u>James Doherty (son)</u> Address <u>Bellw Spring, Md. 8607 Springdale St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary insufficiency</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of left breast. Pneumonia.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>65</u> , to <u>present</u> , that (I) (we) last saw the deceased alive on <u>10/29/67</u> , and that death occurred at <u>Bethesda</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John B. Umhau</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU MD.</u>		22d. ADDRESS <u>8805 CONN. AVE. CHEVY CHASE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	
23d. LOCATION (City or Town) <u>Silver Spring, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>			
25a. REC'D BY REGISTRAR <u>NOV 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14073

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4822 - Cherry Chase</u>	
3. NAME OF DECEASED (Type or print) <u>Frank J. Donahue</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Gas Light Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Donahue</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Pagan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>57707-4920A</u>	
17. INFORMANT <u>Mrs. Constance D. Fletcher</u>		Address <u>5648 - 194 St. Arl. ARLINGTON, VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Squamous cell carcinoma skin of thumb with</u> DUE TO <u>diffuse metastasis.</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Bell</u>		22. DATE SIGNED <u>10/24/67</u>	
EXAMINER'S NAME (Type) <u>John S. Bell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-26-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glewood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W.</u>		25a. REC'D BY REGISTRAR <u>OCT 26 1967</u>	
ADDRESS <u>Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2540

[Faint, illegible handwriting]

CERTIFICATE OF DEATH

14063

14074

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Saint Hosp</u>		d. STREET ADDRESS <u>Silver Spring</u> <u>Georgia Ave & Blair</u>	
3. NAME OF DECEASED (Type or print) <u>Douglas F. Dorton</u>		4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1902</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>15</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER'S HELPER</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Giant Food Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Dorton</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Hurd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wife</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lt. Ventricular Failure</u> DUE TO (b) <u>Aortic stenosis</u> DUE TO (c) <u>(Possible) Rheumatic valvulitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>5 yrs</u> <u>Chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>10-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-13</u> 19 <u>67</u> , and that death occurred at <u>12</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>R. L. Sengstack M.D.</u>		22b. DATE SIGNED <u>10-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George F. Sengstack</u>		22d. ADDRESS <u>9241 Columbia Blvd. Silver Springs, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monte Vesta</u>	23d. LOCATION (City or Town) (County) (State) <u>Mercer County W. Va.</u>
24. FUNERAL DIRECTOR <u>Bene. Payne Jr.</u> 3901 N. Fairfax Dr. Arlington Funeral Home		25a. REC'D BY REGISTRAR <u>OCT 23 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

14024

GENERAL OF DEATH

1504

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "GENERAL", "DEATH", and "14024" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14070

14075

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Virginia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Triangle d. STREET ADDRESS 47 Grand Park Apartments e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kelly Middle Anne Last DOUDS		4. DATE OF DEATH Month October Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 3
11. BIRTHPLACE (County & State, or foreign country) Quantico, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John C. Douds		14. MOTHER'S MAIDEN NAME Delfina Marie Hocho	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	17. INFORMANT Hospital records Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7630 IMMEDIATE CAUSE (a) Pneumonitis, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that he (this hospital) attended the deceased from Oct. 23 , 1967, to Oct 25 , 1967, that he (we) last saw the deceased alive on Oct. 25 , 1967, and that death occurred at 1230 A.M. from causes and on the date stated above.			
22a. SIGNATURE Gene P. Swartz, M.D.		22b. DATE SIGNED Oct. 26, 1967	
22c. PHYSICIAN'S NAME (Type) Gene P. Swartz, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National
23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home 1500 W. Broad St. Alexandria, Va. FAIRFAX, VIRGINIA		25a. REC'D BY REGISTRAR ACT 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

2308

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14071 Item #9 Film #G39, 11/13/67 ph									
CERTIFICATE OF DEATH									
14076									
1. PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>MONTG.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN 1b <u>85 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u> <u>4001 Randolph Road</u>					d. STREET ADDRESS <u>7713 Eastern Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachel (RAY)</u>					4. DATE OF DEATH <u>Duke</u>		Month <u>10</u> Day <u>16</u> Year <u>1967</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-28-1885</u>		9. AGE (In years lost birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>INS WIFE</u>			11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(UNKNOWN) Levy</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>HERBERT A. DUKE, SON, BETHESDA, MD.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>17 HOURS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>2</u> <u>FRACTURE HIP - GARGANIC BRAW DISTACK</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>10-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-4</u> , 19 <u>67</u> , and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>L.S. Blumenthal MD</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-16 67</u>		
22c. PHYSICIAN'S NAME (Type) <u>LESTER S. BLUMENTHAL</u>					22d. ADDRESS <u>5315 CONN. AVE NW</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID</u>			23d. LOCATION (City or Town) (County) (State) <u>FALL CHURCH VA.</u>		
24. FUNERAL DIRECTOR <u>Joe. Lawler's Serv. Inc. Wash. D.C.</u>					25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14077

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>20A</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>Box 123</u>	
3. NAME OF DECEASED (Type or print) <u>Eric</u> First <u>Michael</u> Middle <u>Duvall</u> Last		4. DATE OF DEATH <u>Oct. 29</u> 19 <u>67</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 25, 1967</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9c. AGE (In years last birthday) yrs. <u>7</u> Months <u>3</u> Days <u>3</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	10c. BIRTHPLACE (State or foreign, country) <u>MARYLAND</u>
11. BIRTHPLACE (State or foreign, country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Clipper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Rosalie Duvall</u> Address <u>item # 2 (Mother)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (d) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.		22. DATE SIGNED <u>10/29/67</u>	
EXAMINER'S NAME (Type) <u>John B. Bell</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>OCT. 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Seneca Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Seneca Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14073

CERTIFICATE OF DEATH

14078

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10210 Glen Rd.</u>		d. STREET ADDRESS <u>10210 Glen Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>DVORSKY</u> Last <u>DVORSKY</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1883</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Bartholomew Soukup</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kolar</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Daughter</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> <u>15 YRS</u> <u>30 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>64</u> to <u>Oct 17</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/13, 1967</u> , and that death occurred at <u>4:20 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W. G. Hall</u>		22b. DATE SIGNED <u>10/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. G. HALL</u>		22d. ADDRESS <u>615 W. Montgomery Ave. Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>10-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Thomas Judge</u>			

14078

LIBRARY OF CONGRESS

14078

GENERAL INFORMATION
PUBLISHED BY THE
LIBRARY OF CONGRESS

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14079

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY North Lawrence	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 1148 Glenway Ave., Northwest	
3. NAME OF DECEASED (Type or print) First James Middle Allen Last EVANOVICH		4. DATE OF DEATH Month Oct. Day 12 Year 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1943
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 24
11. BIRTHPLACE (State or foreign country) Franklin, Tuscarawas, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Frank Evanovich		14. MOTHER'S MAIDEN NAME Elizabeth M. (Not Known)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 2-20-64 to 10-12-67		16. SOCIAL SECURITY NO. 276 38 0596	
17. INFORMANT Marine Corps Records		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Hemorrhage from Aortic Aneurysm DUE TO (b) Trauma, Auto Accident DUE TO (c) 40 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto involved in accident	
20c. TIME OF INJURY Month, Day, Year 1:20 Hour a.m. 9-4 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Charlestown South Caro.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball M.D.		22. DATE SIGNED 10/13/67	
EXAMINER'S NAME (Type) John G. Ball, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 10-18-67	23c. NAME OF CEMETERY OR CREMATORY Brookfield Cemetery	23d. LOCATION (City or Town) (County) (State) Massillon, Ohio
24. FUNERAL DIRECTOR Falls Church Funeral Home, 1102 West Broad Street, Falls Church, Virginia		25a. REC'D BY REGISTRAR OCT 17 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11073

Ohio

Memorandum

Re: (initial)

10 Days

North Carolina

Novel Hospital

2118 Broadway Ave., Baltimore

James E. Eganovich

James

X

John

Sept. 10, 1973

U. S. Marine Corps

Franklin, Pennsylvania, Ohio

Michael Frank Eganovich

Albany, N. Y. (New York)

U. S. Marine Corps

10-20-73 to 10-21-73

10-21-73

Marine Corps Hospital

Truman, Ohio Resident

Personnel to be involved in meeting

John C. Bell, MD

10-18-73 - Brookfield Community, Franklin, Ohio

John C. Bell, MD, 102 West Broad

Street, Columbus, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
14075														
14080														
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1826 Vernon Street, NW									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Mattie Marie Fairfax					4. DATE OF DEATH Month Day Year October 20 19 67									
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/1897		9. AGE (In years last birthday) 70 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Warrenton, Va.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME Andrew Williams					14. MOTHER'S MAIDEN NAME Ella Holmes									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Nursing Home Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 446X IMMEDIATE CAUSE (a) H. U. hemorrhage due to renal disease DUE TO (b) disease DUE TO (c) nephrosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio sclerotic heart disease; diabetes mellitus										INTERVAL BETWEEN ONSET AND DEATH 2 weeks				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 13 Oct 1967 to 20 Oct 1967, that (I) (we) last saw the deceased alive on 18 Oct 1967 and that death occurred at 3:45 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Emerson Williams					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-20-67							
22c. PHYSICIAN'S NAME (Type) Emerson Williams, M.D.					22d. ADDRESS 705 Kenyon St., NW, Wash., DC									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/24/67		23c. NAME OF CEMETERY OR CREMATORY Warrenton		23d. LOCATION (City, town or county) (State) Warrenton, Virginia							
24. FUNERAL DIRECTOR Moser Funeral Home Warrenton Va					25a. REC'D BY REGISTRAR DATE OCT 23 1967					25b. REGISTRAR'S SIGNATURE J Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

- CLEARED BY DR. REAP

MONTGOMERY MARYLAND											
SILVER SPRING 11 days											
HOLY CROSS HOSPITAL											
HENRIETTE B. FEINBERG											
F CAUC. WIDOWED 1/10/86 11:40 AM 10/24/1967											
Housewife Own Home New York N.Y. U.S.A.											
William F. Berkowitz Frances Ehrlich											
No 218 - 38-8040 Mrs. Sidney Faber 3603 Isbell Sr. S.S. Md.											
1538 Metastatic carcinoma											
Bilateral bronchopneumonia											
Carcinoma of colon with											
widespread visceral & skeletal metastases											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19											
20d. INJURY OCCURRED While at work Not While at work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 10/16/1967, to 10/27/1967, that (I) (we) last saw the deceased alive on 10-27-1967, and that death occurred at 11:40 AM, from causes and on the date stated above.											
22a. SIGNATURE Henry W. Jaeger M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED 10/28/67											
22c. PHYSICIAN'S NAME (Type) Henry W. Jaeger 22d. ADDRESS 1015 Spring St., Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF Oct. 30, 1967 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory 23d. LOCATION (City or Town) (County) (State) Prince Georges County Md.											
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey Inc. 8434 Georgia Ave S.S. 25a. REC'D BY REGISTRAR NOV 2 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge											

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-1085. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14082

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HENRY</u> Last <u>FISCHER SR</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13-1904</u> 63
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAXI DRIVER</u>		9b. AGE (In years last birthday) yrs. <u>63</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>577-50-6727</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN HENRY FISCHER SR.</u>	
14. MOTHER'S MAIDEN NAME <u>MARY AGNES CODY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>MARY AGNES CODY SON</u>		17. INFORMANT <u>JOHN H FISCHER SR</u> Address <u>4812 Rockford Dr Hyattsville Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, posterior</u> DUE TO (b) <u>Coronary arteriosclerosis with occlusion</u> DUE TO (c) <u>Cerebral contusion + Fracture. Lb + Hb</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>16 days</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head - and fell causing fracture of left hip</u>	
20c. TIME OF INJURY Month, Day, Year <u>9/23 1967</u> Hour <u>9:30</u> a.m. <u>p.m.</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>10/11/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE THEREOF <u>16 OCT. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u>	
23d. LOCATION (City or Town) <u>WASHINGTON D.C.</u>		23e. REC'D BY REGISTRAR <u>OCT 18 1967</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO</u>		25b. REGISTRAR'S SIGNATURE <u>SILVER SPRING, MD</u>	

14052

WEDNESDAY, FEBRUARY 10, 1954

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14083

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN lb DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE 20852 d. STREET ADDRESS 10201 GROSSENER PLACE #97L e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE M FISHER		4. DATE OF DEATH Month Day Year OCT. 29 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 6, 1896
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. WILLIS FISHER		14. MOTHER'S MAIDEN NAME MARY QUIGLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1st WW		16. SOCIAL SECURITY NO.	
17. INFORMANT ELSIE FISHER - WIFE - SAME		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal aneurysm, ruptured DUE TO (b) arteriosclerosis DUE TO (c) 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH Instant 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John E. Ball EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 10/30/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 2-1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Md
24. FUNERAL DIRECTOR Simmons Bros. ADDRESS 1661-Good Hope Rd SE Wash DC		25a. RECD BY REGISTRAR NO. 1 DATE 1967	25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D.C.

FROM THE CHIEF, BUREAU OF REVENUE, WASHINGTON, D.C.

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D.C.

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14084

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13105 Grenoble Drive</u>		d. STREET ADDRESS <u>13105 GRENABLE DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>THOMAS</u> Last <u>FISHER</u>		4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-16</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>17</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK L. FISHER</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE STONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-05-4381</u>	
17. INFORMANT <u>OFFICER HRAPCHAK</u>		Address <u>WHEATON STATION POLICE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound in head</u> DUE TO (b) <u>with cerebral laceration</u> DUE TO (c) <u>and Exsanguination</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased, depressed, shot self in head while in auto in front of home</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:00 P.M. 10-17-1967</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Street</u>	
20e. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20f. PLACE OF INJURY (City or town) (County) (State) <u>Rockville Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>10/17/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (If not city, town or county) <u>Washington</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 20 1967</u>	
ADDRESS <u>1 Rock Pike Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14080

14085

| | | | | | |
|--|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND b. COUNTY
PRINCE GEORGE'S | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LANGLEY PARK Hyattsville 16-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON SANITARIUM & HOSPITAL | | | d. STREET ADDRESS
1432 UNIVERSITY BLVD. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
AUSTIN Elton E. FLUENT | | | 4. DATE OF DEATH
Month OCTOBER Day 16 Year 1967 | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-14-07 | 9. AGE (In years last birthday)
60 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BARBER | | 10b. KIND OF BUSINESS OR INDUSTRY
Barbering | | 11. BIRTHPLACE (State or foreign country)
MAINE | |
| 13. FATHER'S NAME
CLARENCE FLUENT | | | 14. MOTHER'S MAIDEN NAME
ALICE Unknown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
001-14-6315 | | 17. INFORMANT
Dorothy H. Fluent WIFE Address
1432 University Blvd. Hyattsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Acute Coronary Insufficiency
DUE TO (b) Arteriosclerotic Heart & Disease
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
10/17/1967 | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | 23b. DATE THEREOF
Oct. 17, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory | 23d. LOCATION (City or Town) | (County) | (State)
Prince Georges Co., Md. |
| 24. FUNERAL DIRECTOR
Clark & Wisor | | ADDRESS
8434 Georgia Avenue | | 25a. REC'D BY REGISTRAR
DCT 19 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |
| Warner & Pumphrey, Inc. | | Silver Spring, Md. | | | |

1402

1402

THIRD GRADE

MARYLAND

MONTGOMERY

LANGLEY PARK

BOA

THIRD GRADE

THE UNIVERSITY BLVD

WASHINGTON SANITARIUM HOSPITAL

WASHINGTON E. FLUENT

October 10

1-1-13

MALE WHITE

MAINE

BABER

ALICE

CLARENCE FLUENT

1-1-13

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14081

14086

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 15-1 | |
| c. LENGTH OF STAY IN 1b
years | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7116 Exfair Road | | d. STREET ADDRESS
7116 Exfair Road | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) CORA First Middle Last FOULKE | | 4. DATE OF DEATH
Month Oct. Day 4 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 26, 1880 86 yrs. |
| 9. AGE (In years lost birthday) yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
Penna. |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | |
| 13. FATHER'S NAME
George Gardner | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT Daughter Address
Jean E. Foulke Same as Item 2. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADENOCARCINOMA OF GALL BLADDER
DUE TO
(b) WITH METASTASES TO LIVER
DUE TO
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH
1 YR |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from FEB. 19 67 to OCT. 4, 19 67 , that (I) (was) last saw the deceased alive on OCT. 4 19 67 , and that death occurred at 12 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Leo M. Curtis | | 22b. DATE SIGNED
10-5-67 | |
| 22c. PHYSICIAN'S NAME (Type)
LEO CURTIS | | 22d. ADDRESS
8218 Wisconsin Ave. Bethesda, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10-7-67 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Rock Cemetery | 23d. LOCATION (City or Town) (County) (State)
Lewistown, Penna. |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
DATE OCT 16 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

14082

CERTIFICATE OF DEATH

14087

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>WASHINGTON, DC.</u> b. COUNTY <u>47-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WHEATON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WASHINGTON</u> | |
| c. LENGTH OF STAY IN 1b
<u>15 days</u> | | d. STREET ADDRESS
<u>4201 MASS.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>RANDOLPH HILLS Nursing Home</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>EARL BENNETT FRANK</u> | | 4. DATE OF DEATH
Month Day Year
<u>10 25 1967</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>NOV 21 1893</u> |
| 9. AGE (In years last birthday)
<u>73 yrs.</u> | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>DENTIST</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>DENTIST</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>RHODE ISLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>CRAWFORD PHILIP FRANK</u> | | 14. MOTHER'S MAIDEN NAME
<u>MRS. AUGUSTA CHAMPLIN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>YES W.W.I.</u> | | 16. SOCIAL SECURITY NO.
<u>579-60-3344T</u> | |
| 17. INFORMANT
<u>CATHERINE T. FRANK, WIFE, SAME AS #2</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 CORONARY OCCLUSION</u>
DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>
DUE TO (c) <u>Several years</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>10/15/67</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Diverticulitis - abscess formation - Colonotomy in Aug 1967</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>ALSO HAD EMPHYSEMA.</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August, 1960</u> , to <u>10/25, 1967</u> that (I) (we) last saw the deceased alive on <u>10/24 1967</u> , and that death occurred at <u>9:55 A</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>R. S. Williams</u> | | 22b. DATE SIGNED
<u>10/25/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>R. S. WILLIAMS</u> | | 22d. ADDRESS
<u>35 NEW YORK AVE NW.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>10/28/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>FT. LINCOLN CEM.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>BLADENSBURG, MD.</u> |
| 24. FUNERAL DIRECTOR
<u>JOS. GAWLER'S SONS, 5130 WIS. AVE. NW, WASH., D.C.</u> | | 25a. REC'D BY REGISTRAR
<u>NOV 1 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

1905

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>SOA</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i> | | d. STREET ADDRESS <i>11603 Park Edge Dr</i> | |
| 3. NAME OF DECEASED
(Type or print) <i>Daniel Herman Franks</i> | | 4. DATE OF DEATH
Month <i>October</i> Day <i>3</i> Year <i>1967</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>January 22-1914</i> |
| 9. AGE (In years lost birthday) <i>53</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tax Attorney</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOVT</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Cleveland - Ohio</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>MORRIS FRANKS</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown -</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes WWII</i> | | 16. SOCIAL SECURITY NO. <i>293-01-8609</i> | |
| 17. INFORMANT <i>Mrs Daniel Franks</i> | | Address <i>Above</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>
4201
DUE TO <i>Coronary arteriosclerosis with occlusion</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <i>19</i> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>John M. Ball</i> M.D. | | 22. DATE SIGNED <i>Oct 4, 1967</i> | |
| EXAMINER'S NAME (Type) <i>John M. Ball</i> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 23b. DATE THEREOF <i>10/8/67</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>ZION MEM. PARK</i> | 23d. LOCATION (City or Town) (County) (State) <i>BEDFORD, OHIO</i> |
| 24. FUNERAL DIRECTOR <i>Goetzberg Funeral Home</i> | | 25a. REC'D BY REGISTRAR <i>4217-9-Rec</i> | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14089

14084

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>3301 Cummings Lane</u> | |
| 3. NAME OF DECEASED (Type or print) <u>John</u> First Middle <u>Carlos</u> <u>FRANZONI</u> | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1967</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 15, 1908</u> 9. AGE (In years lost birthday) <u>59</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tech. Assist.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Reserve Gov.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Fred. Royce Franzoni</u> | | 14. MOTHER'S MAIDEN NAME <u>Bessie Jones</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Kathryn Franzoni wife</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Coronary Thrombosis - Acute</u>
DUE TO (b) <u>Cardio Vascular Disease</u>
DUE TO (c) <u>Years</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> - NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>John G. Ball</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED <u>10/8/67</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10/11/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Washington, D. C.</u> | | 25a. REC'D BY REGISTRAR <u>OCT 10 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

1985

John D. Hall

John D. Hall

Continental Company, Inc.

Continental Company, Inc.

Continental Company, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14085

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14090

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>20 YRS.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11712 Georgia Ave.</u> | | d. STREET ADDRESS <u>11712 Georgia Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>HENRY</u> Last <u>FUNK</u> | | 4. DATE OF DEATH Month <u>OCT.</u> Day <u>9</u> Year <u>1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-12-1917</u> |
| 9. AGE (In years last birthday) <u>50</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. GOV'T.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>PENNA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>WILLIAM JOSEPH FUNK JR.</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY AGNES KELLY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> (If yes, give year or dates of service) <u>U. S. ARMY</u> | | 16. SOCIAL SECURITY NO. <u>167-01-5489</u> | |
| 17. INFORMANT <u>MRS. LAVERNE E. FUNK (WIFE)</u> | | Address (SAME) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to Bronchogenic Carcinoma.</u>
DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1957</u> to <u>Oct. 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 1, 1967</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Selden R. Reap</u> M.D. | | 22b. DATE <u>Oct. 9, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>SELDEN R. REAP, M.D.</u> | | 22d. ADDRESS <u>Wheaton, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u> | | 23b. DATE THEREOF <u>Oct. 12, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Alleghany Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Mcandles Township, Pa.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | 25c. ADDRESS <u>Silver Spring, Maryland</u> | |

MEDICAL CERTIFICATION

12 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared with Dr. Reap/ Medical Examiner at 3:00PM 10/13/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|------------------------------|--|---|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 14086 | | | | | 14091 | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | c. LENGTH OF STAY IN lb
4 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Beltsville, Maryland | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | | | | d. STREET ADDRESS
10425 Balt. Ave. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print) Lucretia D. Gano | | | | | 4. DATE OF DEATH
10-13 | | Month 10 Day 13 Year 1967 | | | |
| 5. SEX
f | | 6. COLOR OR RACE
w | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10-27-5-23-67 | | 9. AGE (In years last birthday) 75 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
home | | 11. BIRTHPLACE (County & State, or foreign country)
West Va | | | 12. CITIZEN OF WHAT COUNTRY?
U S A | | |
| 13. FATHER'S NAME
William C Daniels | | | | | 14. MOTHER'S MAIDEN NAME
Betty Hendricks | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16. SOCIAL SECURITY NO.
214 48 6160 | | 17. INFORMANT
Marion E Gano | | | Address
Beltsville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation
DUE TO Acute myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-2 , 19 67 , to 10-13 , 19 67 , that (I) (we) last saw the deceased alive on 10-13 19 67 and that death occurred at 2:30 PM , from causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
Bonne G. Bender | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10-14-67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
F. Gasch's Sons | | | | | 22d. ADDRESS
Hyattsville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
Oct 16, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Washington D. C. | | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons | | | | | ADDRESS
Hyattsville, Md. | | 25a. REC'D BY REGISTRAR
OCT 16 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

10001

3201

STATEMENT OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

ETHNICITY

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY
<i>Montgomery</i>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Bethesda</i> | | c. LENGTH OF STAY IN 1b
<i>17 days</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Washington D.C.</i> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Suburban Hospital</i> | | d. STREET ADDRESS
<i>3503 PATTERSON ST. N.W.</i> | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
<i>BERNARD</i> | | 4. DATE OF DEATH
Month <i>Oct</i> Day <i>20</i> Year <i>1967</i> | |
| 5. SEX
<i>male</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>11/28/91</i> |
| 9. AGE (In years last birthday)
<i>75</i> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Lawyer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Retired</i> | 11. BIRTHPLACE (State or foreign country)
<i>Johnstown Pa</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 13. FATHER'S NAME
<i>Bernard Garvey Jr.</i> | |
| 14. MOTHER'S MAIDEN NAME
<i>Johanna Flinn</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Intracranial hemorrhage, left cerebral hemisphere, massive</i>
DUE TO <i>331X</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>due to cerebral arteriosclerosis</i>
DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<i>Fracture of Pelvis - Left - Pubic bone</i> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<i>Fall in nursing home causing fracture Pelvis</i> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. TIME OF INJURY Month, Day, Year
<i>10/3 1967</i> | |
| 20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work at work | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<i>nursing home</i> | |
| 20e. (City or town) (County) (State)
<i>Bethesda Montgomery Md.</i> | | 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 22. ACTUAL SIGNATURE
<i>John L. Ball</i>
EXAMINER'S NAME (Type) | | 22. DATE SIGNED
<i>Oct 20, 1967</i> | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<i>Oct. 23, 1967</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Silver Spring Mont. Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Horton Funeral Home</i> | | 25a. REC'D BY REGISTRAR
DATE <i>OCT 30 1967</i> | |
| ADDRESS
<i>4748 Wisc. Ave. N.W.</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

2000-1

STATE OF CALIFORNIA

2000-1

2000-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14088

14093

| | | | |
|--|---------------------------|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Hazel Grace Gates</u> | | 4. DATE OF DEATH <u>10-16</u> 19 <u>67</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-9-89</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Koch</u> | | 14. MOTHER'S MAIDEN NAME <u>Ellen Muffy</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>579-281294</u> | |
| 17. INFORMANT <u>John E. Bates</u> | | Address <u>Someas 2d</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO (b) <u>Coronary artery arteriosclerosis</u>
DUE TO (c) <u>Chronic arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
<u>5 years</u>
<u>5 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> , 19 <u>65</u> to <u>Oct 16</u> , 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Oct 15</u> 19 <u>67</u> , and that death occurred at <u>11 AM</u> , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>Michael N. Judge</u> | | 22b. DATE SIGNED <u>Oct 16, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10-19-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u> | |
| 24. FUNERAL DIRECTOR <u>Lee Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>302 4th St. N.E.</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Lee Funeral Home</u> | | DATE <u>OCT 18 1967</u> <u>Michael N. Judge</u> | |

COPI 1

STATE OF TEXAS

1883

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "State of Texas" and "County of" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|--------------------------------------|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
e. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Washington b. COUNTY D.C. | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Kensington | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
District of Columbia | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Carroll Hall | | | | | d. STREET ADDRESS
6309 33rd. St. N.W. | | | | |
| 3. NAME OF DECEASED
(Type or print) Eli Zabe Th. | | | | | 4. DATE OF DEATH
Month 10 Day 24 Year 1967 | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/13/85 | | 9. AGE (In years last birthday)
82 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Germany | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Willhelm Bierenfeld | | | | | 14. MOTHER'S MAIDEN NAME
Maria Butterling | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
203-14-8638D | | 17. INFORMANT
Address Mrs. Helen G. Trolle (daughter) same item #2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Respiratory Failure.
1810 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Carcinoma of lung with pneumonia
Cancer of bladder. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs.
6 months.
5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1963 , 19... to 10/24 , 19 67 , that (I) (we) last saw the deceased alive on 10/23 , 19 67 , and that death occurred at 9 M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
[Signature] | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10/24/67 | | |
| 22c. PHYSICIAN'S NAME (Type)
S. A. Thomas M.D. | | | | | 22d. ADDRESS
4301 48th St. N.W. Washington D.C. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Bur-Transit | | 23b. DATE THEREOF
10/26/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | | | 23d. LOCATION (City, town or county) (State)
Clermont, Florida | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Tyson Wheeler Funeral Home | | | | | 25a. REC'D BY REGISTRAR
1371 Rockville Pike Rockville, Md. | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |
| DATE OCT 26 1967 | | | | | | | | | |

14001

14001

STATE OF OHIO

County of Hamilton

Shirley M. Smith

10-24-68

10-24-68

10-24-68

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10-24-68

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14090

14095

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH
COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Michigan</u> COUNTY <u>Benuee</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | c. LENGTH OF STAY IN 1b
<u>57 min</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Flushing</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Suburban Hospital</u> | | | | d. STREET ADDRESS
<u>5424 MAURA DRIVE</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) <u>Eli</u> First <u>(none)</u> Middle <u>Goldin</u> Last | | | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>12</u> Year <u>1967</u> | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Apr 30, 1874</u> | |
| 9. AGE (In years last birthday)
<u>92-93</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Self-employed</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Shoe Repairman</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Satvia, Rumania</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | | | | 13. FATHER'S NAME
<u>Sam Goldin</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Riva</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No.</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>365-34-5651A</u> | | | | 17. INFORMANT <u>add. same address above</u>
<u>Howard Goldin - son</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute -</u>
DUE TO (b) <u>Cardio-Vascular Disease</u>
DUE TO (c) <u>years</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 22. ACTUAL SIGNATURE
<u>John G. Ball</u> | | | | 22. DATE SIGNED
<u>10/12/67</u> | | | |
| EXAMINER'S NAME (Type)
<u>JOHN G. BALL, M.D.</u> | | | | 23a. BUREAU OF HEALTH
<u>Flint, Michigan</u> | | | |
| 23b. DATE THEREOF
<u>10-13-67</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Washington DC</u> | | | |
| 23d. LOCATION (City or Town) _____ (County) _____ (State) _____ | | | | 23e. REC'D BY REGISTRAR
<u>OCT 13 1967</u> | | | |
| 23f. REGISTRAR'S SIGNATURE
<u>Bernard Danzansky & Sons</u> | | | | 23g. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

1893

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1893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Florida
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | c. LENGTH OF STAY IN lb
12 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Merritt Island |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | d. STREET ADDRESS
812 Hampton Way | |
| 3. NAME OF DECEASED
(Type or print)
Eva First Y. Middle GOULDING Last | | 4. DATE OF DEATH
Month October Day 5 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 23, 1910 |
| 9. AGE (In years last birthday)
57 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
N/A | 11. BIRTHPLACE (County & State, or foreign country)
Fort Kent, Maine |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Fabien Pinette | |
| 14. MOTHER'S MAIDEN NAME
Modeste Laferiere | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Merritt Island Address Florida
Mr. Orin K. Goulding, 812 Hampton Way | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
7545 IMMEDIATE CAUSE (a) Congenital Heart Disease (Atrial Septal Defect)
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from Sept. 23, 1967 , to Oct. 5, 1967 , that he (we) last saw the deceased alive on Oct. 5, 1967 , and that death occurred at 200P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Perry Ah-Tye | | 22b. DATE SIGNED
Oct. 6, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Perry Ah-Tye, MD | | 22d. ADDRESS
Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, UNKNOWN (Specify)
Burial | 23b. DATE THEREOF
10-10-67 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia |
| 24. FUNERAL DIRECTOR Lee Funeral Home ADDRESS D. C. | | 25a. REC'D BY REGISTRAR
OCT 11 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |
| 4th and Massachusetts Ave., N.E. Washington, / | | | |

14002

DEPARTMENT OF HEALTH

14002

RECEIVED (1911) 12-25-11
NAVY HOSPITAL
WASHINGTON, D.C.

RECEIVED (1911) 12-25-11
NAVY HOSPITAL
WASHINGTON, D.C.

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NAVY HOSPITAL
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WASHINGTON, D.C.

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NAVY HOSPITAL
WASHINGTON, D.C.

RECEIVED (1911) 12-25-11
NAVY HOSPITAL
WASHINGTON, D.C.

CERTIFICATE OF DEATH

14097

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dickerson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dickerson</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>R.F.D. #2</u> | | d. STREET ADDRESS
<u>R.F.D. #2</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>THOMAS</u> Middle <u>GRAHAM</u> Last <u>GRAHAM</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>28</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 9, 1887</u> |
| 9. AGE (In years last birthday)
<u>80</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Tilghman Graham</u> | | 14. MOTHER'S MAIDEN NAME
<u>Winnie Betters</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Mrs. Mildred Graham</u> | | Address <u>216 Rolling Ave E. Orange, N.J.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a</u>
DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>advanced arteriosclerosis</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 5, 1967</u> , to <u>Oct 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>27 Oct</u> 1967, and that death occurred at <u>6 P.</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John J. Lawrence</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>Nov. 3, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Warren Chapel Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Martinsburg Montg. Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Robert L. Snowden</u> | | 25a. REC'D BY REGISTRAR
<u>Rockville, Md.</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>John Charles Judge</u> | | DATE <u>NOV 6 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1903

RECEIPT OF DEPOSIT

THE NATIONAL SAVINGS BANK OF NEW YORK

| | |
|-----------------|--|
| No. 1000 | |
| Date of Deposit | |
| Amount | |
| For | |
| By | |
| Signature | |
| Witness | |
| Bank Officer | |
| Branch | |
| City | |
| State | |
| Post Office | |
| County | |
| District | |
| Country | |

1903

14093

CERTIFICATE OF DEATH

14098

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CABIN JOHN</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CABIN JOHN</u> 151 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>6510 76th PLACE.</u> | | d. STREET ADDRESS
<u>6510 76th PL.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>LEWIS</u> Middle <u>A.</u> Last <u>GREGORY</u> | | 4. DATE OF DEATH
Month <u>OCT.</u> Day <u>20</u> Year <u>1967</u> | |
| 5. SEX
<u>M.</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>MAR 12, 1887</u> |
| 9. AGE (In years last birthday) yrs. <u>80</u> | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>N. C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>JOHN T. GREGORY</u> | | 14. MOTHER'S MAIDEN NAME
<u>AMANDA</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>242-16-8881</u> | |
| 17. INFORMANT
<u>MRS. SPATES (DAUGHTER)</u> | | Address
<u>SAME</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia Congestive Heart Failure</u>
4500 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis & paraplegia</u>
DUE TO (c) <u>5 yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>63</u> , to <u>Oct</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/18</u> , 19 <u>67</u> , and that death occurred at <u>10A</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>James J. Foster</u> | | 22b. DATE SIGNED
<u>10/20/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
<u>1746 K St. N.W.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>OCT 23, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>CUR LADY OF GAWALYDE</u> | 23d. LOCATION (City or Town) (County) (State)
<u>NEWTON GROVE N.C.</u> |
| 24. FUNERAL DIRECTOR
<u>Robert A. D. Tolp</u> | | 25a. REC'D BY REGISTRAR
<u>Washington DC</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>OCT 24 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10001-1

RECEIVED

SEP 31

10001-1
10001-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completed in the presence of the funeral director. After this certificate has been signed by the attending physician and completed in the presence of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 14099 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laytonsville
c. LENGTH OF STAY IN 1b 50 Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 2 Gaithersburg | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laytonsville
d. STREET ADDRESS Rt. 2 Gaithersburg
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) LILLIAN NEEL GRIFFITH | | | | | 4. DATE OF DEATH
Month Oct. Day 18 Year 19 67 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 5 1883 | | 9. AGE (In years last birthday) 84 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (County & State, or foreign country) Montgomery Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | | | | | | |
| 13. FATHER'S NAME James B. Neel | | | | | 14. MOTHER'S MAIDEN NAME Katharine Hoyle | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. Isabella G. Willett | | | | | 17. INFORMANT Same as 2 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4221 DUE TO (b) Glaucoma, bilateral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 years 5 years | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that (I) James P. Kerr attended the deceased from 8/15 to 10/18 , 19 67 that (I) James P. Kerr saw the deceased alive on 10/14 , 19 67 , and that death occurred at 7:35 PM from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE James P. Kerr M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22b. DATE SIGNED 10/18/67 | | | | |
| 22c. PHYSICIAN'S NAME (Type) Damascus Md | | | | | 22d. ADDRESS Damascus Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 20 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Neelsville | | 23d. LOCATION (City, town or county) (State) Neelsville Montgomery co. Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Francis H Barber | | | | | ADDRESS Laytonsville Md. | | | | | 25a. REC'D BY REGISTRAR OCT 20 1967 25b. REGISTRAR'S SIGNATURE Francis H Barber Md. | | | | |

James H. Barber

Raytownville

Oct 20 1967

Neelaville

Montgomery Co.

James P. Kerr

Danvers

Id

Oct. 20 1967

Neelaville

Neelaville

Montgomery Co.

Isabella G. Willett

No

Katharine

Holy

Montgomery Co. Md.

U.S.A.

James B. Neel

House Wife

Female White

Sept. 2 1883

84

NEEL

CRITTH

Oct.

18

84

Oct. 2

Gatherburg

Oct. 2

Gatherburg

20 years

Raytownville

Raytownville

Montgomery

Harvard

Montgomery

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14095

CERTIFICATE OF DEATH

14100

| | | | | | |
|--|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>---</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>4 Days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Alexandria</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center</u> | | | d. STREET ADDRESS
<u>1102 Trinity Drive</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>(NMN)</u> Last <u>Grossman</u> | | | 4. DATE OF DEATH
Month <u>October</u> Day <u>27</u> Year <u>1967</u> | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>17 February 1915</u> | | 9. AGE (In years lost birthday) <u>52</u> yrs.
IF UNDER 1 YEAR: Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Insurance Agent</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Insurance</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>New York</u> | |
| 13. FATHER'S NAME
<u>Samuel Grossman</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>068-22-7346</u> | | |
| 17. INFORMANT
<u>The Medical Records, The Clinical Center, Bethesda, Maryland</u> | | | 18. ADDRESS
<u>20014</u> | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary congestion and atelectasis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Macroglobulinemic Lymphoma</u>
DUE TO
(c) <u>---</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>1-2 Days</u>
<u>2 Years</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>---</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>23 October, 1967</u> , to <u>27 October 1967</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>27 October 1967</u> , and that death occurred at <u>12:01 A.M.</u> from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>Timothy G. Canty</u> | | | 22b. DATE SIGNED
<u>27 October 1967</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Timothy G. Canty, MD.</u> | | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>10-29-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Agudas Achim Cemetery</u> | | 23d. LOCATION (City or Town)
<u>Alexandria</u> | (County) <u>Va.</u> (State) |
| 24. FUNERAL DIRECTOR
<u>Goldberg Funeral Home, 4217 9th St., N.W.</u> | | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | DATE
<u>OCT 30 1967</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1910

STATE OF OHIO

1910

[The remainder of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document.]

CERTIFICATE OF DEATH

14096

14101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>
c. LENGTH OF STAY IN 1b <u>1 yr. 8 mos.</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>WASHINGTON D.C.</u>
b. COUNTY <u>47-3</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4740 Conn. Ave. N.W.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>ABRAHAM</u>
First Middle Last
4. DATE OF DEATH <u>OCTOBER# 26 19 67</u>
Month Day Year | | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/3/95</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>OSCAR HAFT</u> | | 14. MOTHER'S MAIDEN NAME <u>EVA HOFFMAN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>577-34-6923</u> 17. INFORMANT <u>ABRAHAM HAFT</u> Address <u>4540 Conn. Ave. N.W. WASHINGTON, D.C.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
DUE TO (b) <u>Cerebral Arteriosclerosis</u>
DUE TO (c) <u>more than 5 years</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>331X</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 6, 1966</u> , to <u>Oct 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 26, 1967</u> , and that death occurred at <u>3 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Warren D. Brill</u> | | 22b. DATE SIGNED <u>10/26/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>WARREN D. BRILL, M. D.</u> | | 22d. ADDRESS <u>2601 16th St. N. W. Washington, D. C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10-29-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH - VA</u> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <u>B. Danzansky + Sons</u> ADDRESS <u>3501-14th St N.W. Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR DATE <u>OCT 30 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14097

CERTIFICATE OF DEATH

14102

| | | | | | | | |
|--|--|---|---------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
New Jersey
b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN 1b
15 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Nutley | | 67-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
The Clinical Center, Bethesda, Maryland | | | | d. STREET ADDRESS
25 Highfield Lane | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Kevin Joseph Haines | | | | 4. DATE OF DEATH
Month Day Year
October 13 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9 June 1961 | | 9. AGE (In years lost birthday) yrs.
6 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (County & State, or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert F. Haines | | | | 14. MOTHER'S MAIDEN NAME
Ann Claire Longworth | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
The Medical Records, The Clinical Center, Bethesda, Maryland 20014 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory collapse</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Brain involvement with lymphoma</u>
DUE TO
(c) <u>Poorly differentiated lymphosarcoma</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 minutes
6 weeks
3 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (X) (this hospital) attended the deceased from <u>28 September 1967</u> , to <u>13 October 1967</u> , that (IX) (we) lost saw the deceased alive on <u>13 October 1967</u> , and that death occurred at <u>6:55M</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Charles M. Haskell, MD</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> A.M. STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
13 October 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Charles M. Haskell, MD | | | | 22d. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10-16-67 | 23c. NAME OF CEMETERY OR CREMATORY
Mary Rest Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Darlington N.J. | | | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE OCT 18 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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STATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

| <div>14098</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14103</div> | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Edgewater | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban | | | | | | d. STREET ADDRESS
Rt #1, Box 208 | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Francis First X Middle Harlow Last | | | | | | 4. DATE OF DEATH
Month October Day 17 Year 1967 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
5/13/1939 | | 9. AGE (In years last birthday) yrs. 28 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Elec. Mechanic | | | | 10b. KIND OF BUSINESS OR INDUSTRY
POWER Co. | | 11. BIRTHPLACE (State or foreign country)
Canada | | | 12. CITIZEN OF WHAT COUNTRY?
U.S | | |
| 13. FATHER'S NAME
Wm. McShath | | | | | | 14. MOTHER'S MAIDEN NAME
Mary Simmons | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) U.S. Coast Guard Res. | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
EVA A. HARLOW Address #2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
9143 IMMEDIATE CAUSE (a) Electrocution -
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 hours | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Touched a live wire that should have been dead. | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 8:20 Oct 17 1967 | | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Power Station | | 20f. (City or town) (County) (State)
R. Garth'sburg - Mont. Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John S. Ball M.D. | | | | | | 22. DATE SIGNED Oct 17, 1967 | | | | | |
| EXAMINER'S NAME (Type) JOHN S. BALL | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
10-20-67 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEM. | | 23d. LOCATION (City or Town) (County) (State)
PRINCE GEORGE CO. MD | | | | | |
| 24. FUNERAL DIRECTOR
John M. Taylor Son Annapolis Md | | | | | | 25a. REC'D BY REGISTRAR
OCT 19 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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THE UNIVERSITY OF CHICAGO

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CERTIFICATE OF DEATH

14104

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | |
| c. LENGTH OF STAY IN 1b
30 Years | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
7209 Chestnut Street | | d. STREET ADDRESS
7209 Chestnut Street | |
| 3. NAME OF DECEASED
(Type or print)
First FRANK Middle HASTINGS Last HARRISON | | 4. DATE OF DEATH
Month October Day 9 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 7, 1892 |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months 15 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Real Estate | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 11. BIRTHPLACE (State or foreign country)
London, England | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
John Harrison | | 14. MOTHER'S MAIDEN NAME
Phoebe Keg | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
578-09-2514 | |
| 17. INFORMANT
Wife | | Address
Same as Item 2. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cholangiocarcinoma, multiple of liver
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.
(b) _____
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
10 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1942 to Oct 9 , 19 67 , that I last saw the deceased alive on Oct 7 , 19 67 , and that death occurred at 6:44 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stewart Clapp | | ADDRESS (Street, city or town, state) 4740 Chevy Chase Dr. Oct 9, 1967 | |
| PHYSICIAN'S NAME (Type) Stewart Clapp M.D. | | DATE SIGNED Oct 9, 1967 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-12-67 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Rockville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
ROBERT A. PUMPHREY, Bethesda, Maryland | | 24a. REC'D BY REGISTRAR
DATE OCT 16 1967 | |
| | | 24b. REGISTRAR'S SIGNATURE
Charles J... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 2 and 7. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glen Echo | | c. LENGTH OF STAY IN lb
20 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
48 Wellesley Circle | | d. STREET ADDRESS
48 Wellesley Circle | |
| 3. NAME OF DECEASED
(Type or print) HOWARD W. HARRISON | | 4. DATE OF DEATH
Month Oct. Day 31 , Year 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
July 1, 1907 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Warehouseman | | 10b. KIND OF BUSINESS OR INDUSTRY
Plumbing Sup. | 9. AGE (In years last birthday) yrs. 60 |
| 11. BIRTHPLACE (County & State, or foreign country)
Oklahoma | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME
William Henderson Harrison | | 14. MOTHER'S MAIDEN NAME
Josephine Elizabeth Mark | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
577-07-0884 | |
| 17. INFORMANT
Wife | | Address
Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute pulmonary edema
DUE TO (b) Hypoxemia
DUE TO (c) Emphysema | | INTERVAL BETWEEN ONSET AND DEATH
18 mos
5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from April, 1966 , to October 2, 1967 , that (I) (we) last saw the deceased alive on Oct. 26, 1967 , and that death occurred at 7:30 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
R.W. Langguth, M.D. | | 22b. DATE SIGNED
Oct 31 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
R.W. Langguth, MD | | 22d. ADDRESS
1234 19th St. N.W. Wash. DC. | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
11-2-67 | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State)
Prince George County, Md. |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
NOV 2 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

11103

RECORD OF DEATH

11103

Montgomery

Montgomery

Montgomery

John

20 years

John

48 William Street

48 William Street

Oct. 31,

HOSPITAL, HARTFORD

July 1, 1907

White

Male

William

William

William

Josephine Elizabeth

William Henderson

Name as given

577-07-0884

No

14101

CERTIFICATE OF DEATH

14106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/>
a. STATE <u>West Virginia</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | c. LENGTH OF STAY IN 1b
<u>5 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Pettus</u> 25-3 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Maryland</u> | | | | d. STREET ADDRESS
<u>(None)</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) | | First <u>James</u> Middle <u>Richard</u> Last <u>Hash</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>28</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 22, 1965</u> | | 9. AGE (In years last birthday)
<u>2</u> yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James A. Hash</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Phyllis Payne</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT <u>The Medical Record</u> Address
<u>The Clinical Center, Bethesda, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pseudomonas septicemia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Wiskott-Aldrich syndrome</u>
DUE TO
(c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 days</u>
<u>2 1/2 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> o.m. p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct. 23, 1967</u> , to <u>Oct. 28, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct. 28, 1967</u> , and that death occurred at <u>9:12 M.</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Charles M. Haskell</u> | | | | A.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
M.D. ATTENDING PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>Oct. 28, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Charles M. Haskell, M.D.</u> | | | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<u>10-30-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State)
<u>Pettus W Va</u> | |
| 24. FUNERAL DIRECTOR
<u>Prozin 389 B.I. see n.w. road</u> | | | | 25a. REC'D BY REGISTRAR
<u>OCT 31 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

30111

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14102

CERTIFICATE OF DEATH

14107

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON Sanitarium & Hospital | | d. STREET ADDRESS
7327 Carroll Ave | |
| 3. NAME OF DECEASED
(Type or print)
RHEE DOROTHEA HAUGHN | | 4. DATE OF DEATH
Month 10 Day 17 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/31/21 |
| 9. AGE (In years lost birthday)
46 yrs. | | IF UNDER 1 Year
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Legal Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY
LAW FIRM | |
| 11. BIRTHPLACE (County & State, or foreign country)
CANADA | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
CREIGHTON HAUGHN | | 14. MOTHER'S MAIDEN NAME
MILDRED CONRAD | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, if unknown, write UNKNOWN)
UNKNOWN | | 16. SOCIAL SECURITY NO.
015-14-7520 | |
| 17. INFORMANT
Creation Haughn, Sr. | | Address
7327 Carroll Ave. Takoma Park, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hem. Masses
DUE TO 4201
(b) Coronary Thrombosis
DUE TO 28hrs
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
28hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/21/67 , 19 67 , to 10/17/67 , 19 67 , that (I) (we) last saw the deceased alive on 10/16/67 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Howard T Morse | | 22b. DATE SIGNED
10/17/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Howard T Morse | | 22d. ADDRESS
7030 Carroll Avenue, Takoma Park, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 20, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR
Warner E. Humphrey, Inc. | | 25a. REC'D BY REGISTRAR
DATE OCT 23 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

625

12-13-81

12

- 1 -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14103

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> 20910 b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TAKOMA PARK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>WASHINGTON SAN & HOSPITAL</u> | | d. STREET ADDRESS
<u>8540 2nd Ave #3</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Celia</u> Middle <u>(None)</u> Last <u>Havice</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>28</u> Year <u>1967</u> | |
| 5. SEX
<u>FE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-12-76</u> |
| 9. AGE (In years lost birthday) yrs.
<u>91</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>retired</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Penn.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>JAMES BOONE</u> | | 14. MOTHER'S MAIDEN NAME
<u>Amanda Love</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>192-10-6376</u> | |
| 17. INFORMANT
<u>Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO (c) <u>4200</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>many years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Fracture Left Hip</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<u>not known</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Fall at Home 3 weeks prior to death</u> | |
| 20c. TIME OF INJURY Month, Day, Year
<u>not known</u> 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | 20f. (City or town) (County) (State)
<u>Silver Spring, Montg. Md.</u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-9-</u> 19 <u>67</u> to <u>10-28-</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-27-</u> 19 <u>67</u> , and that death occurred at <u>4:25</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Jay A. McRoberts</u> | | 22b. DATE SIGNED
<u>10-28-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JAY A. McROBERTS</u> | | 22d. ADDRESS
<u>1400 Spring Street Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, or other disposition
<u>Burial</u> | 23b. DATE THEREOF
<u>10/29/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Coulterville Cem.</u> | 23d. LOCATION (City or town) (County) (State)
<u>Westmorland Co. Pa.</u> |
| 24. FUNERAL DIRECTOR
<u>Robert A. Pumphrey</u> | | 25a. REC'D BY REGISTRAR
<u>NOV 1 1967</u> | |
| ADDRESS
<u>Bethesda, Md.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. [Signature]</u> | |

12303

10/29/57

10/29/57

10/29/57

10/29/57

10/29/57

10/29/57

10/29/57

10/29/57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

14104

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14109

| | | | |
|---|---------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>7 1/2 hrs</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | 16-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u> | | d. STREET ADDRESS <u>7002 Highview Terrace</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Albert</u> Last <u>Heath</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-23-46</u> |
| 9. AGE (In years lost birthday) yrs. <u>20</u> | | IF UNDER 1 YEAR Months <u>10</u> Ooys <u>19</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>University of Md</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Heath</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Isabelle Shapiro</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u> <u>Unknown</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>HOSP. Record</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized, severe, subarachnoid and</u>
DUE TO
(b) <u>intracranial hemorrhage due to</u>
OUT TO
(c) <u>auto accident.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased was passenger in auto when driver lost control colliding with a car.</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>11:50 PM</u> <u>10/18/1967</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>Street</u> | | 20f. (City or town) (County) (State) <u>Adelphi Pr.Geo. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>10/19/1967</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE THEREOF <u>Oct. 20, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>W W Chambers Co. 8655 62 Ave Silver Spring Md</u> | | 25a. REC'D BY REGISTRAR <u>OCT 23 1967</u> | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

1. The first question is whether the applicant is a citizen of the United States. The answer is yes.

2. The second question is whether the applicant is a resident of the United States. The answer is yes.

3. The third question is whether the applicant is a native-born citizen of the United States. The answer is yes.

4. The fourth question is whether the applicant is a naturalized citizen of the United States. The answer is yes.

5. The fifth question is whether the applicant is a citizen of the United States by descent. The answer is yes.

6. The sixth question is whether the applicant is a citizen of the United States by marriage. The answer is yes.

7. The seventh question is whether the applicant is a citizen of the United States by adoption. The answer is yes.

8. The eighth question is whether the applicant is a citizen of the United States by naturalization. The answer is yes.

9. The ninth question is whether the applicant is a citizen of the United States by birth. The answer is yes.

10. The tenth question is whether the applicant is a citizen of the United States by birthright. The answer is yes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14103

14110

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo.</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>#yattsville</u> 16.2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sanitarium & Hospital</u> | | d. STREET ADDRESS
<u>8135 15th Ave. Apt. 203</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Ethel</u> First <u>Maud</u> Middle <u>Higgins</u> Last | | 4. DATE OF DEATH
Month <u>October</u> Day <u>2</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>October 19, 1892</u> 77 |
| 9. AGE (In years last birthday) yrs. <u>74</u> | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>R.N. retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>England</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William Head</u> | | 14. MOTHER'S MAIDEN NAME
<u>Thirza Biddlescomb</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>376-30-9944A</u> | |
| 17. INFORMANT
<u>Hospital Records</u> | | Address
<u>7600 Carroll Ave.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>URemia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Metastatic CA of Cervix</u>
DUE TO
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-23-67</u> , 19 <u>67</u> , to <u>10-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-1</u> , 19 <u>67</u> and that death occurred at <u>2:15</u> A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>ES Cushman</u> | | 22b. DATE SIGNED
<u>10-2-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u> </u> | | 22d. ADDRESS
<u>11161 New Hampshire Ave.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 23b. DATE THEREOF
<u>2 Oct. 67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Lee Crematory</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, DC</u> | |
| 24. FUNERAL DIRECTOR
<u>Rinaldi Funeral Home</u> | | 25a. REC'D BY REGISTRAR
<u>DC 20012</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>OCT 3 1967</u> | |

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UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14106

14111

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Texas</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TAKOMA PARK</u> | | c. LENGTH OF STAY IN 1b
<u>2 months 16 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington San & Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Clara Randolph Hill</u> | | 4. DATE OF DEATH
Month <u>10</u> - Day <u>16</u> - Year <u>1967</u> | |
| 5. SEX
<u>Fe</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>5-18-97</u> |
| 9. AGE (In years lost birthday) yrs. <u>70</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House wife</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Georgia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>William Howard</u> | | 14. MOTHER'S MAIDEN NAME
<u>Florence Moore</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO.
<u>346-16-7892</u> | |
| 17. INFORMANT
Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO (b) <u>INCREASING INTRACRANIAL PRESS 2 months</u>
(c) <u>PRIMARY BRAIN TUMOR (GRADE III) 3 1/2 months</u>
(ASTROCYTOMA) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Minimal</u> (L) <u>CHF</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour: a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-31</u> , 19 <u>67</u> , to <u>10-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-16</u> , 19 <u>67</u> , and that death occurred at <u>7:50 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John L Ford</u> | | 22b. DATE SIGNED
<u>10-17-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN LOUIS FORD, MD</u> | | 22d. ADDRESS
<u>831 UNIVERSITY BLVD E. SILVER SPRING, MD</u> | |
| 23a. BURIAL, CREMATION, or other disposal (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>10/19/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Oak Wood Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Mt. Vernon, Illinois</u> |
| 24. FUNERAL DIRECTOR
<u>Francis Gasch's Sons</u> | | 25a. REC'D BY REGISTRAR
<u>OCT 19 1967</u> | |
| ADDRESS
<u>4739 Baltimore Ave Hyattsville, Md. 20781</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John Charles Jones</u> | |

69157

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14107

CERTIFICATE OF DEATH

14112

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
D.C.
b. COUNTY
Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton | | c. LENGTH OF STAY IN TB
1 1/2 mos. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
University Nursing Home | | d. STREET ADDRESS
1401 A Buchanan Street, N.W. | |
| 3. NAME OF DECEASED
(Type or print)
Susanna nmn | | 4. DATE OF DEATH
Month 10 Day 14 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
Caus. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/22/1882 |
| 9. AGE (In years lost birthday)
85 yrs. | | 10. IF UNDER 1 YEAR
Months 10 Days 14 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Jefferson County, W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Joseph Robert Howell | | 14. MOTHER'S MAIDEN NAME
Jeanne Susan Miller | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
578-48-5734 | |
| 17. INFORMANT
Edna O. Waugh-daugh | | Address Takoma Pk., Md. 7309 Wildwood Dr. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
DUE TO Probable Basilar Artery Thrombosis
(b) 2° Arteriosclerotic Disease
DUE TO (c)
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
Death occurred Oct. 14, 1967 | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 1967 to Oct. 14, 1967 , that (I) (we) last saw the deceased alive on Oct. 13, 1967 , and that death occurred at 9:25 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
R.C. Bufalino | | 22b. DATE SIGNED
Oct. 14, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
R.C. BUFALINO | | 22d. ADDRESS
1429 Univ. Blvd W. Silver Spring | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10-18-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cem. | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor, Maryland |
| 24. FUNERAL DIRECTOR
Lee Fun. Home | | 25a. REC'D BY REGISTRAR
300 4th St. NE, Wash., D.C. | |
| 25b. REGISTRAR'S SIGNATURE
John A. Judge | | DATE
OCT 17 1967 | |

19107

DEPARTMENT OF DEATH

19107



RECEIVED
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DEPARTMENT OF DEATH
19107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4421 Brooklyn Lane</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u>
b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>
d. STREET ADDRESS <u>4421 Brooklyn Lane</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Gertrude Fay Hoage</u>
First Middle Last
4. DATE OF DEATH <u>Oct 13 1967</u>
Month Day Year | | 5. SEX <u>F</u>
6. COLOR OR RACE <u>W.</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>WASH DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>WALTER BROWN</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY ELIZ. B. FORD</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY NO. <u>217-44-6411</u> | | 17. INFORMANT <u>Allen W Hoage</u>
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>
DUE TO <u>Coronary Artery Disease</u>
(b) <u>Generalized Arteriosclerosis</u>
DUE TO <u>Hyperextension</u>
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hyperextension</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
<u>15 yrs</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 20, 1967</u> to <u>Oct 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 9, 1967</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>E. Herbert Bauersfeld</u>
22c. PHYSICIAN'S NAME (Type) <u>E. Herbert Bauersfeld</u> | | 22b. DATE SIGNED <u>10/13/67</u>
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <u>2401 Calvert St. N.W.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>10-16-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u> |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>
ADDRESS | | 25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

11111

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10-23-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14109

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14114

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK
c. LENGTH OF STAY IN TB
D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON SANITARIUM & HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK
d. STREET ADDRESS
1014 EAST-WEST HIGHWAY
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
CARROLL ARCHIE HODGES | | 4. DATE OF DEATH
Month 10 - Day 10 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-4-17 |
| 9. AGE (In years lost birthday) yrs.
50 | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MAIL CARRIER | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt | |
| 11. BIRTHPLACE (State or foreign country)
NORFOLK, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JOHN HODGES | | 14. MOTHER'S MAIDEN NAME
ADELIA WHITEHURST | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES | | 16. SOCIAL SECURITY NO.
579-32-9009 | |
| 17. INFORMANT
Mrs. Mary Hodges | | Address
1014 East West Hwy
Takoma Park Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary insufficiency and
DUE TO 4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congestive heart failure due to
DUE TO
(c) Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 22. DATE SIGNED
Oct. 10, 1967 | | 23. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 24. ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | 25. ADDRESS (Street, City, County)
5792 La
Son Funeral Home Ave | |
| 26. BURIAL, CREMATION, REMOVAL (Specify)
10/14/67 Mt O. Unit Cem | | 27. DATE THEREOF
10/14/67 | |
| 28. NAME OF CEMETERY OR CREMATORY
Wash DC | | 29. LOCATION (City or Town) (County) (State)
Wash DC | |
| 30. FUNERAL DIRECTOR
W. J. Hunte | | 31. REC'D BY REGISTRAR
DATE OCT 16 1967 | |
| 32. REGISTRAR'S SIGNATURE
Charles Judge | | 33. ADDRESS
5792 La
Son Funeral Home Ave | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|------------------------------|---|------------------------------------|
| 141110 | | 141115 | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRINGS | | c. LENGTH OF STAY IN 1b
WHEATON, MD. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
HOLY CROSS HOSPITAL | | d. STREET ADDRESS
1722 FRANWALL AVE. | |
| 3. NAME OF DECEASED
(Type or print) GEORGE First Middle Last HOLTZAPPEL | | 4. DATE OF DEATH
Month October Day 12 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/18/89 |
| 9a. AGE (In years last birthday) 78 yrs. | | 9. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| 11. BIRTHPLACE (County & State, or foreign country)
York County Pa | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George A Holtzapfel | | 14. MOTHER'S MAIDEN NAME
Amanda Pieffer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
197-03-3892 | |
| 17. INFORMANT
Ethel Newsom | | Address
1722 Franwall Ave Wheaton Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure
DUE TO (b) Arteriosclerotic Heart Disease.
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April , 19 59 , to 10-12 19 67 that (I) (we) last saw the deceased alive on 10-12 19 67 , and that death occurred at 11:30 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Golden R. Reap | | 22b. DATE SIGNED
10-13-1967 | |
| 22c. PHYSICIAN'S NAME (Type)
BELDEN R. REAP M.D. | | 22d. ADDRESS
Wheaton, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct 16 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Lewisburg Cemetery | | 23d. LOCATION (City or town) (County) (State)
Lewisburg Pennsylvania | |
| 24. FUNERAL DIRECTOR
Warner & Pumphrey, Inc | | 25a. REC'D BY REGISTRAR
OCT 20 1967 | |
| ADDRESS
8434 Ga Ave Sil Spg Md | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14111

CERTIFICATE OF DEATH

14116

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>DELAWARE</u> b. COUNTY <u>Kent</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>FREDERICK</u> | |
| c. LENGTH OF STAY IN 1b
<u>3 yrs 8 mo.</u> | | d. STREET ADDRESS
<u>46.3</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>FAIRLAND NURSING HOME 2101 FAIRLAND</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Lillian</u> Middle <u>A</u> Last <u>Hopkins</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>13</u> Year <u>1967</u> | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/18/1887</u> |
| 9. AGE (In years lost birthday)
<u>80</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Kent Co. Delaware</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>TITOMAS ALEXANDER</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>MARY QUILLEN</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO.
<u>222-22-6465-A</u> | | 17. INFORMANT
<u>Homer Hopkins, Beltsville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ch. Myocarditis</u>
<u>4222</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 28</u> , 19 <u>67</u> , to <u>Oct 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 13</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Robert S. McCeney, M.D.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ROBERT S. MCCENEY, M.D.</u>
402 MAIN ST.
LAUREL, MARYLAND 20810 | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>10/16/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Barratts' Chapel</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Fredricka, Kent, Del.</u> |
| 24. FUNERAL DIRECTOR
<u>John C. Barr</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>OCT 18 1967</u> | |

10111

CERTIFICATE OF DEATH

11111

1250 Elmwood Rd.
Baltimore, Md.

10/10/10

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14112

14117

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
c. LENGTH OF STAY IN b. <u>2 1/2 yrs.</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1503 Menlee Drive</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 151
d. STREET ADDRESS <u>1503 Menlee Drive</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
First Middle Last
<u>Oscar (NMN) HORVATH</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>10 2 1967</u> | | | | | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Nov. 27 1895</u> | | 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Teacher</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>School</u> | | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Szenicz, Hungary</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>Hungary</u> | |
| 13. FATHER'S NAME
<u>Morton Horvath</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Maria Unknown</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | | | 17. INFORMANT
Address <u>1503 Menlee Dr.</u>
<u>Dr. William Tolgyesi, Silver Spring, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular Disease</u>
(a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>24 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from <u>March 1967</u> to <u>October 1967</u> , that (I) (we) last saw the deceased alive on <u>October 2 1967</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Morton A. Schuler</u> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED
<u>Oct 2, 1967</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Morton A. Schuler, M.D.</u> | | | | | | 22d. ADDRESS
<u>9205 New Hampshire Ave. Silver Spring, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 23b. DATE THEREOF
<u>10/6/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven</u> | | | | 23d. LOCATION (City, town or county) (State)
<u>Wheaton Montgomery City, Md</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>W. W. Chambers Co.</u> | | | | | | ADDRESS
<u>8655 Co Ave Silver Spring, Md.</u> | | | | 25a. REC'D BY REGISTRAR
<u>OCT 5 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

524

5121

CERTIFICATE OF DEATH

141113

141118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
c. LENGTH OF STAY IN lb <u>1 hr. 35 min</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Dist Md</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
d. STREET ADDRESS <u>166175 Westland Dr</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>James C Hurley</u>
First Middle Last
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/30/84</u> 83 | | 4. DATE OF DEATH <u>Oct 27 1967</u>
Month Day Year
9. AGE (In years lost birthday) <u>83</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. Employee</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>Herb Hurley</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura Cline</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>287-10-3342A</u> 17. INFORMANT <u>Wife</u>
<u>Ida C. Hurley</u> Address <u>Same as Item 2.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u>
DUE TO (b) <u>491X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Indirect inguinal hernia with incarcerated loop of sigmoid and early moist gangrene.</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/27, 1967</u> to <u>10/27, 1967</u> that (I) (we) last saw the deceased alive on <u>10/27, 1967</u> , and that death occurred at <u>12:37 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert R. Montgomery</u> M.D. | | 22b. DATE SIGNED <u>10/27/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ROBERT R. MONTGOMERY</u> | | 22d. ADDRESS <u>5411 CEDAR LAKE BETHESDA</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10/31/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Woodland Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Xenia, Ohio</u> | |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> | | 25a. REC'D BY REGISTRAR <u>NOV 1 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-----------------------------------|---|--|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 141114 | | | | | | | | | | | |
| 141119 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | c. LENGTH OF STAY IN 1b <u>8 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> 15-1 | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Salvation Hospital</u> | | | | | d. STREET ADDRESS <u>7017 Meadow Lane</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>B.</u> Last <u>Ingersoll</u> | | | | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1967</u> | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-11-09</u> | | 9. AGE (In years lost birthday) yrs. <u>58</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>William Bigelow Ingersoll</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Constance Harriet B. Belt</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Cousin</u> <u>O. S. Belt</u> | | Address <u>7021 Meadow Lane Chevy Chase, Md.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent and remote</u>
DUE TO
(b) <u>coronary arteriosclerosis with occlusion</u>
DUE TO
(c) <u></u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1947</u> , to <u>Oct 11, 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Oct 11, 1967</u> , and that death occurred at <u>12:30 A.M.</u> from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Stewart Clapp</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>Oct 11 1967</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u> | | | | | 22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10-14-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Perkins Chapel Cem.</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Springfield, Maryland</u> | | | | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR <u>DA</u> <u>OCT 18 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | |

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Northampton

Butterfield

Chambers

Waller

Robt. Webb

Ratner

To

Mr

Chapman

2017 Market

2-11-09

28

Thompson

James B. Pitt

2021

2-11-09

2021 OCT 18 1921

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14115

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14120

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garthursburg</u> | |
| c. LENGTH OF STAY IN lb <u>52 days</u> | | d. STREET ADDRESS <u>Box 273</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Nathan</u> Middle <u>J</u> Last <u>Jackson</u> | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>28</u> Year <u>1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 29, 1932</u> |
| 9. AGE (In years last birthday) yrs. <u>35</u> | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Nathan Jackson</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Robinson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>MARY NEAL - (sister) Box 273</u> | | Address <u>Garthursburg, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia. Bronchial. confluent bibl.</u>
DUE TO (b) <u>Encephalo. Malacia -</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Burns of body.</u>
INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u>
<u>52 days.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell asleep when smoking in bed.</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>11:30</u> a.m. <u>p.m.</u> <u>Sept 2</u> <u>1967</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | 20f. (City or town) (County) (State) <u>Garthursburg Montgomery Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John S. Ball</u> M.D. | | 22. DATE SIGNED <u>10/29/67</u> | |
| EXAMINER'S NAME (Type) <u>John S. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>Nov. 4, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Clarksburg Montg. Md.</u> |
| 24. FUNERAL DIRECTOR <u>Robert L. Suorden</u> | | 25a. REC'D BY REGISTRAR <u>NOV 6 1967</u> | |
| ADDRESS <u>Rockville, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u> | |

11130

11130

NOV 1951

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14121

| | | | |
|---|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK
c. LENGTH OF STAY IN 1b
15-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON SANITARIUM & Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
M.D.
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SPENCERVILLE
d. STREET ADDRESS
15419 BATSON ROAD
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
ROBERT ALVIN JENKINS | | 4. DATE OF DEATH
Month 10 Day 6 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-13-42 |
| 9. AGE (In years last birthday)
25 yrs. | | 10. IF UNDER 1 YEAR
Months 10 Days 6 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
skull metal worker | | 10b. KIND OF BUSINESS OR INDUSTRY
same | |
| 11. BIRTHPLACE (State or foreign country)
M.D. | | 12. CITIZEN OF WHAT COUNTRY?
M.D. | |
| 13. FATHER'S NAME
JOSEPH JENKINS | | 14. MOTHER'S MAIDEN NAME
ROBERTA HAIRFIELD | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-40-6679 | |
| 17. INFORMANT
DRIVERS LICENSE | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple skull fractures with
DUE TO avulsion of cerebral substance
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) due to auto accident
(c) due to auto accident | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Deceased was passenger in auto when driver lost control and struck four trees. | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 7:25 p.m. 10/6 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | | 20f. (City or town) (County) (State)
Silver Spring Montg Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | 22. DATE SIGNED
Oct. 7, 1967 | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | Address (City or town, county)
Baltimore Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct 9, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Union Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md | |
| 24. FUNERAL DIRECTOR
Arthur Walters, 234 Carroll Ave. Wash DC | | 25a. REC'D BY REGISTRAR
DATE OCT 11 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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14117

CERTIFICATE OF DEATH

14122

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

W. J. White, D. covering for R. Denech, D. please sign & file

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> <u>Silver Spring</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring Md.</u> | | c. LENGTH OF STAY IN TB | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Fairland Nursing Home</u> | | d. STREET ADDRESS
<u>8625 Piney Branch Road</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Elmer Johnson</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>29</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9/7/70</u> |
| 9. AGE (In years lost birthday)
<u>97</u> yrs. | | 10. IF UNDER 1 Year
Months <u>29</u> Days <u>19</u> Hours <u>67</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired printer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>G.P.O.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Norway</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>578-44-3191</u> | |
| 17. INFORMANT
<u>A Dorothy K. Nichols</u> | | Address
<u>910 Hedin Dr. Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>
<u>4200</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>a congestive failure</u>
(c) <u>1 day</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Tumor? left lower lobe</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>22 Aug</u> , 19 <u>67</u> , to <u>29 Oct</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>29 Oct</u> , 19 <u>67</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above | | | |
| 22a. SIGNATURE
<u>Merton Z. White</u> | | 22b. DATE SIGNED
<u>29 Oct 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Merton Z. White</u> | | 22d. ADDRESS
<u>9911 Georgia Ave., Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>11/1/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Prince Georges County, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>SH HINES Co.</u> | | 25a. REC'D BY REGISTRAR
<u>NOV 1 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | 25c. ADDRESS
<u>2901 145TH AVE</u> | |

SSN 1

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Blank ledger page with horizontal ruling lines.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Case closed by Medical Examiner, Dr. E. J. Fisher, Jr.

| | | | | | |
|--|--|--|---|---|--|
| 14118 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 14123 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring, | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring, Maryland | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Nora Jane Johnson | | | 4. DATE OF DEATH
Month Day Year
10 26 19 67 | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
8/21/84 | | 9. AGE (In years lost birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 11b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Locust Grove Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
John Tinder | | 14. MOTHER'S MAIDEN NAME
Esther Tinder Norris | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
225-10-0605 | | 17. INFORMANT
Dorothy Ansell
Holy Cross Hosp. 8 Marigold Ct. SSMD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Nonanergic shock.</u>
451X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Leading abdominal aortic aneurysm.</u>
DUE TO (c) <u>Arteriosclerosis.</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
7 hours
24 hours
10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>17 Aug.</u> , 19 <u>67</u> , to <u>26 Oct.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>17 Aug.</u> 19 <u>67</u> , and that death occurred at <u>10:15</u> M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Herbert T. Kimble | | 22b. DATE SIGNED
10-26-67 | | 22c. PHYSICIAN'S NAME (Type)
Dr. Seruch J. Kimble | |
| 22d. ADDRESS
921 Pendling Dr. Silver Spring, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 30, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Comfort Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Alexandria, Virginia | | 23e. REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |
| 23f. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 23g. ADDRESS
8434 Georgia Ave. Silver Spring, Md | | | |
| 23h. DATE
NOV 2 1967 | | | | | |

11133

11133

RECEIVED

RECEIVED

11133

11133

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14119

14124

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Virginia
b. COUNTY MARTINSVILLE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
MARTINSVILLE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Althea Woodland Nursing Home | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) ELIZABETH W. JOHNSTON | | 4. DATE OF DEATH
Month Oct. Day 19 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 27, 1886 |
| 9. AGE (In years last birthday) yrs. 81 | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
none | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Stafford G. Whittle | | 14. MOTHER'S MAIDEN NAME
Ruth R. Drewry | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
no | |
| 17. INFORMANT
Whittle Johnston Chevy Chase, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c) Chronic nephritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic nephritis | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Belden R. Reap M.D. | | 22. DATE SIGNED 10/20/67 | |
| EXAMINER'S NAME (Type) BELDEN R. REAP, M.D. | | Address (Street, City, Town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 23, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Roanoke, Virginia | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey | | 25a. REC'D BY REGISTRAR
BETHESDA, MD. | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE OCT 25 1967 | |

14134

14119

MAE INEVILLE

Silver Spring

Clinton St.

Alison Woodland, Reading House

27

Oct. 10, 1900

WILKINSON

June 27, 1899

June 27, 1899

U.S.A.

none

W. H. R. Dwyer

W. H. R. Dwyer

Whitely Johnson, Navy Case, W.

no

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

White, Elizabeth, 1890

Oct. 25, 1900

Oct. 25, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| | | | | | |
|---|---|---|--|---|---|
| 14120 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 14125 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | | d. STREET ADDRESS <u>8101 15th Ave</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) <u>Robert Saunders Jones</u>
First Middle Last | | | 4. DATE OF DEATH <u>October 4</u> 19 <u>67</u>
Month Day Year | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/11/91</u> | 9. AGE (In years last birthday) <u>76</u> yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAPER SALES MAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia Paper Co.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Penna</u> | |
| 13. FATHER'S NAME <u>Robert S. Jones -</u> | | | 14. MOTHER'S MAIDEN NAME <u>MARTHA Temple</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>577-03-3559-A</u> | | 17. INFORMANT <u>Frances H. Jones</u> Address <u>8101 - 15th Avenue Hyattsville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
260X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Diabetes mellitus</u> DUE TO
(c) <u>Cerebral Thrombosis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>5-8 yrs</u>
<u>5-8 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 2</u> , 19 <u>57</u> , to <u>Oct 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 4</u> , 19 <u>67</u> , and that death occurred at <u>10:30 PM</u> , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>W.B. Wardrop MD</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>10/5/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>W.B. WARDROP, MD</u> | | 22d. ADDRESS <u>808 PERSHING Dr. Silver Spring Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Oct 7, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u> | |
| 24. FUNERAL DIRECTOR <u>John E. Thomas</u> <u>Warner E. Pumphrey, Inc.</u> | | ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>OCT 9 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Cleared with Dr. B. Reap - apparently natural causes

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14126

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN lb
hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring, | | 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | | | d. STREET ADDRESS
122 Lynmoor Dr. SS Md. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Dennis N Jordan | | | | 4. DATE OF DEATH
Month Day Year
10 27 19 67 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7/22/08 | |
| 9. AGE (In years lost birthday)
59 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
clerk | | 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Frank B. Jordan | | | | 14. MOTHER'S MAIDEN NAME
Bessie Gregory | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
yes WW II | | 16. SOCIAL SECURITY NO.
226-07-1909 | | 17. INFORMANT
Address
wife A.B. Jordan 122 Lynmoor Dr. SSMd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Acute coronary thrombosis
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO (c) _____
INTERVAL BETWEEN ONSET AND DEATH
Undetermined | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from September, 1967, to October 27, 1967, that (I) (we) last saw the deceased alive on September 1967, and that death occurred at 10:45 AM, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Bennet A. Porter Jr. | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
October 27, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Bennet A. Porter, Jr. | | | | 22d. ADDRESS
F. F. Farmer 9301 Colesville Rd., Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 30, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Comfort Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR
Warner E. Humphrey, Inc. | | | | 25a. REC'D BY REGISTRAR
NOV 2 1967 | | 25b. REGISTRAR'S SIGNATURE
John L. Judge | |

1-1-50

RECEIVED

1-1-50

WOLF CANNED MEAT

WOLF CANNED MEAT

1-1-50

1-1-50

1-1-50

1-1-50

1-1-50

1-1-50

14122

CERTIFICATE OF DEATH

14127

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE WASH. D.C.
b. COUNTY WASHINGTON DC. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WHEATON | | c. LENGTH OF STAY IN 1b
57 MONTHS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WHEATON NURSING HOME
11901 GEORGIA AVE. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARIE Middle ANTOINETTE Last JORDAN | | 4. DATE OF DEATH
Month 10 Day 9 Year 19 67 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-28-1873 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
FRANCE | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
BLESBOIS DESIRE | | 14. MOTHER'S MAIDEN NAME
FC.D. Jordan-son | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) General Visceral Failure
DUE TO 4500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis
DUE TO
(c) Senility | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that (I) (this hospital) attended the deceased from June , 19 62 to Oct 9 , 19 67 , that (I) (we) last saw the deceased alive on Sept 26 , 19 67 , and that death occurred at 1130P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Francis E. Sharpe | | 22b. DATE SIGNED
10-9-67 | |
| 22c. PHYSICIAN'S NAME (Type) Francis E. Sharpe | | 22d. ADDRESS
4105 Wisconsin Ave. Wash D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | 23b. DATE THEREOF
10-10-67 | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | 23d. LOCATION (City or Town) _____ (County) _____ (State) Washington, D.C. |
| 24. FUNERAL DIRECTOR
Lee Funeral Home | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| ADDRESS
Washington, D.C. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------------------|--|---|--|---|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| Item #16 Film #G395 11/23/67 ph | | | | | | | | | | | |
| 14122 CERTIFICATE OF DEATH 14128 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> | | | | c. LENGTH OF STAY IN lb <u>3 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u> | | | | | | d. STREET ADDRESS <u>1019 Nora Drive</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Catherine</u> Middle <u>Mary</u> Last <u>Judy</u> | | | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>29</u> Year <u>1967</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 8, 1888</u> | | 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Youngstown, Ohio</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James A. Hennessy</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Clark</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>978-99-9220</u> | | 17. INFORMANT <u>Catherine J. Long</u> Address <u>4305 Elmwood Road Beltsville, Maryland</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4500 IMMEDIATE CAUSE (a) <u>Myxomatous pneumonia (terminal)</u>
DUE TO (b) <u>Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Parkinsonian Syndrome</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/20, 1967</u> to <u>10/29/67</u> , 19 <u>67</u> , that (I) (we) las saw the deceased alive on <u>10/29, 1967</u> , and that death occurred at <u>6:30</u> M, from causes on and the date stated above | | | | | | | | | | | |
| 22a. SIGNATURE <u>R.C. Kirchner</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>Oct. 29, 1967</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>R.C. KIRCHNER</u> | | | | | | 22d. ADDRESS <u>6480 N.H. Ave - Takoma Park. Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov 31, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> Address <u>8434 Georgia Avenue Silver Spring, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>NOV 1 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

1919

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State of New York

County of New York

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TO THE HONORABLE THE COMMISSIONER OF THE LAND OFFICE
STATE OF NEW YORK
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|----------------------------------|---|---|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 14129 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>University Nursing Home</u> | | | | | d. STREET ADDRESS
<u>10500 Rockville pike</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Alice</u> Middle <u>Clara</u> Last <u>Keenan</u> | | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>17</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>Caus.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
<u>6/5/1910</u> | | 9. AGE (in years last birthday) <u>57</u> yrs.
IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>At Home</u> | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Buffalo, New York</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>William Boughton</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Fellows</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>220-44-6615</u> | | 17. INFORMANT
Address <u>Rockville, Md.</u>
<u>Lawrence Keenan, Son, 273 Congressional La.,</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma Breast, c Metastases</u>
<u>170X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u>
DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 1967</u> to <u>10/17/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>10/17/67</u> 19 <u> </u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Henry C. Scruggs MD.</u> | | | | | 22b. DATE SIGNED
<u>10/17/67</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>HENRY C. SCRUGGS MD.</u> | | | | | 22d. ADDRESS
<u>5413 Cedar Lane Bethesda Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial/Transit</u> | | | 23b. DATE THEREOF
<u>10/20/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Forest Lawn Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Buffalo, New York</u> | | |
| 24. FUNERAL DIRECTOR
<u>Joseph G. Gowers, Son Inc. - Wash., D.C.</u> | | | | | 25a. REC'D BY REGISTRAR
<u>OCT 19 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John Charles Judge</u> | | |

11133

11134

Rockville, Md.

Rockville, Md., 11-11-61. Lawrence Korman, 30, 11133 Rockville, Md.

Rockville, Md.

Rockville, Md.

Rockville, Md.

Rockville, Md.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-2, Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14125

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14130

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ROCKVILLE | | c. LENGTH OF STAY IN 1b
4 YRS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ROCKVILLE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
13716 FLINTROCK RD | | | | d. STREET ADDRESS
13716 FLINTROCK RD. | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
CATHERINE B. KENNEDY | | | | 4. DATE OF DEATH
Month Day Year
OCT. 26 1967 | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-30-24 | 9. AGE (In years lost birthday) yrs.
43 | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
SCOTLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John BLACK | | | | 14. MOTHER'S MAIDEN NAME
MARIAN SHAW Gray | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
113-24-0145 | | 17. INFORMANT
HUSBAND (WILTON L) | | Address
SAME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary insufficiency;
DUE TO
(b) Rheumatic heart disease
DUE TO
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | EXAMINER'S NAME (Type)
BELOEN R. REAP M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED
10/26/1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 30, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | |
| 25a. REC'D BY REGISTRAR
NOV 2 1967 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1952

1950

MONTGOMERY

1950

MONTGOMERY

ROCKVILLE

7-22

ROCKVILLE

1510 FORTROCK RD

1510 FORTROCK RD

CATHERINE B

KENNEDY

OCT. 20 62

X

WHITE

7-20 24 42

HOOD WIFE

STANDARD

USA

BLACK

INDIAN SHAW

NO

1950-1951

HARRIS (MONTGOMERY)

SALE

X

X

X

X

Section 10, Township 10, Range 10

Section 10, Township 10, Range 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14128

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14131

| | | | |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring, Md.
c. LENGTH OF STAY in 1b
6 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Belmont Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE M b. COUNTY
District of Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
3805 T Street, N. W.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
ANNIE | | 4. DATE OF DEATH
Month 10 Day 1 Year 1967 | |
| 5. SEX
Fe | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 15, 1882 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
house wife | | 11. BIRTHPLACE (County & State, or foreign country)
Ireland | |
| 13. FATHER'S NAME
Cryan | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
— | |
| 17. INFORMANT
Son | | Address 11815 Enid Dr. Potomac, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY CONGESTION
420.1 DUE TO CORONARY ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO GEN'L ARTERIOSCLEROSIS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OSTEOPOROSIS, ARTHRITIS
INTERVAL BETWEEN ONSET AND DEATH
DAYS
YRS
YRS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Mar 10/1967 to 10/1/1967 , that (I) (we) last saw the deceased alive on 9/30/1967 , and that death occurred at 5 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Donald R. Lewis | | 22b. DATE SIGNED
10/1/67 | |
| 22c. PHYSICIAN'S NAME (Type)
DONALD R. LEWIS | | 22d. ADDRESS
700 CLOVERLY SIL. SPRING MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-4-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION (City, town or county) (State)
Washington, D. C. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
OCT 6 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

10111

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Mar 21 1961
J. Edgar Hoover
Director
FBI
Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 14127 | | | | | | | | | | | |
| 14132 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montg. | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dickerson, Md | | | | c. LENGTH OF STAY IN 15
Yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dickerson, Md (Rural) 15-1 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Richard Middle E. Last King | | | | | | 4. DATE OF DEATH
Month Oct Day 8 Year 67 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/24/1878 | | 9. AGE (In years last birthday) yrs. 88 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Horace King | | | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) DUE TO
(c) DUE TO | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from October, 1966 , to 8 Oct., 1967 , that (I) (we) saw the deceased alive on 7 October 1967 , and that death occurred at 9:54 A.M. from causes on and the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Gordan M. Smith | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
8 Oct 67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Gordan M. Smith, M.D. | | | | | | 22d. ADDRESS
Barnesville, Maryland, 20703 | | | | | |
| 23a. BURIAL, CREMATION, or other final disposition (Specify)
Burial | | 23b. DATE THEREOF
10/11/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Mt. Zion, Md. | | | |
| 24. FUNERAL DIRECTOR
Robert L. Snowden | | | | | | ADDRESS
Rockville, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 10 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1113

DEPARTMENT OF DEATH

1113

Montgomery

Virginia

Monte

Dickerson, M.

Yrs

Dickerson, M. (Hurt)

Richard

King

Yrs

1113

Male

Yrs

1113

Virginia

None

Yrs

Horace King

Unknown

Gordon M. Smith, M.D.

W. E. Eton Cemetery

W. E. Eton, Mo.

1113

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

| MONTGOMERY COUNTY, MARYLAND | | | | | | | | | |
|---|--|--|---|---|---|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | | c. LENGTH OF STAY in 1b
<u>2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | | 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sanatorium & Hospital</u> | | | | | d. STREET ADDRESS
<u>8811 Colesville Road.</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Ignazio Frank LaCavera</u> | | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>24</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>Cauc.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>7-14-01</u> | | 9. AGE (In years last birthday) <u>66</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Barber</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self-employed Barber</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Amer</u> | |
| 13. FATHER'S NAME
<u>Salvatore LaCavera</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Vincinetta Sperandio</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>577-09-8112</u> | | 17. INFORMANT
<u>Elizabeth S. La Cavera</u> Address <u>8811 Colesville Rd. Silver Spring, Md.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4.8 hr.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 2</u> , 1954, to <u>Oct 24</u> , 1967, that (I) (we) last saw the deceased alive on <u>24 Oct 1967</u> , and that death occurred at <u>1:08 PM</u> , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>W. B. Wardrop MD</u> | | | | | 22b. DATE SIGNED
<u>Oct. 24, 1967</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>W. B. Wardrop</u> | | | | | 22d. ADDRESS
<u>808 Pershing Drive Silver Spring, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<u>Oct. 27, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Silver Spring, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>C. Glen Carter</u> 8434 <u>Georgia Avenue</u>
<u>Warner E. Humphrey, Inc.</u> <u>Silver Spring, Md.</u> | | | | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |
| DATE <u>OCT 27 1967</u> | | | | | | | | | |

251A*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

Cleared with Medical Examiner

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 14129 CERTIFICATE OF DEATH 14134 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville Silver Spring</u> | | | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | | | | | d. STREET ADDRESS
<u>13810 Congress Drive</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Lottie Marion Lamb</u> | | | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>28</u> Year <u>1967</u> | | | | | |
| 5. SEX
<u>female</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Nov. 6, 1885</u> | | 9. AGE (In years last birthday)
<u>82</u> yrs. | | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Washington, D. C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | |
| 13. FATHER'S NAME
<u>John Joseph Phillip</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Carrie Cunningham</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>579-18-9746</u> | | 17. INFORMANT
<u>Lewis J Lamb/son</u> Address <u>7513 Maple Avenue, Takoma Park, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
DUE TO (b) <u>Hypertension</u>
DUE TO (c) <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Arteriosclerosis</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u> p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1946</u> , to <u>28 Oct 1967</u> , that (I) <u>(we)</u> lost the deceased alive on <u>Aug 1967</u> , and that death occurred at <u>3:17 PM</u> from causes on and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>William D. And</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>Oct. 28, 1967</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. William D. And</u> | | | | | | 22d. ADDRESS
<u>Colesville, Road Silver Spring, Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Nov. 1, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Glenwood Cemetery</u> | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D.C.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc.</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 1 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

11111

11111

Nov. 1, 1967

[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--------------------------------------|-------------------------|---|---|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 14130 | | | | | 14135 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRINGS | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CHEVY CHASE | | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
CHEVY CHASE NURSING & CONVALESCENT CENTER | | | | | d. STREET ADDRESS
4615 HUNT AVENUE | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) ELIZABETH LANE
First Middle Last | | | | | 4. DATE OF DEATH
OCTOBER 11 19 67
Month Day Year | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
SEPT. 14, 1884 | | 9. AGE (In years lost birthday) yrs.
83 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
KENTUCKY | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
EDWARD WRING | | | | | 14. MOTHER'S MAIDEN NAME
BELLE PERRY | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
NURSING & CONVALESCENT CENTER RECORDS
Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
332X IMMEDIATE CAUSE (a) Uremia -
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cerebral Thrombosis -
DUE TO (c) Generalized Arterio Sclerosis - | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 months
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from Oct - , 19 63 , to date , 19 67 , that (I) (we) last saw the deceased alive on 10 Oct 19 67 , and that death occurred at 6:15 AM from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
John G. Ball | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
Oct. 11, 1967 | | | |
| 22c. PHYSICIAN'S NAME (Type)
John G. Ball | | | | 22d. ADDRESS
7936 Georgetown Rd. Bethesda Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
10/13/67 | | 23c. NAME OF CEMETERY OR CREMATORY
HIGHLAND CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
SOUTH BEND, INDIANA | | |
| 24. FUNERAL DIRECTOR
ROBERT E. WILHELM FUNERAL HOME
4308 SUITLAND ROAD, SUITLAND, MARYLAND | | | | | | 25a. REC'D BY REGISTRAR
OCT 13 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

14133

14133

RECEIVED

RECEIVED

NAVY DEPT

NAVY DEPT

NAVY DEPT

NAVY DEPT

NAVY DEPT

NAVY DEPT

NAVY DEPT

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NAVY DEPT

NAVY DEPT

NAVY DEPT

NAVY DEPT

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14131

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14136

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | | | d. STREET ADDRESS
13009 Arctic Ave. | | | |
| 3. NAME OF DECEASED (Type or print)
First Lewis Middle Phillip Last Lasher | | | | 4. DATE OF DEATH
Month October Day 14 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/7/27 | | 9. AGE (In years last birthday)
40 yrs. | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Govt. agent | | 10b. KIND OF BUSINESS OR INDUSTRY
FDA Govt. | | 11. BIRTHPLACE (State or foreign country)
Denver, Colorado | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Phil Lasher | | | | 14. MOTHER'S MAIDEN NAME
Grace Caldwell | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes W.W. II | | 16. SOCIAL SECURITY NO.
521-30-0895 | | 17. INFORMANT Wife, BeBe Lasher | | Address 13009 Arctic Ave. Rockville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO Coronary Artery Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Heap
EXAMINER'S NAME (Type)
BELDEN R. HEAP M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED
Oct. 14, 1967 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-20-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Crown Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Denver, Colorado | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey
ADDRESS
Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE OCT 16 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

RESULTS

2625

7. 11. 1951

main topic

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

14132

CERTIFICATE OF DEATH

14137

| | | | |
|---|---------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD b. COUNTY ST. MARY'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA (rural) | | c. LENGTH OF STAY IN lb
2 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LEXINGTON PARK |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
US NAVAL HOSPITAL | | d. STREET ADDRESS
5 TANNER AVE | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle MILTON Last LAUGHLIN | | 4. DATE OF DEATH
Month OCT Day 13 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
CAUC | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 12TH 1924 |
| 9. AGE (In years last birthday)
43 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U. S. NAVY | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
BESSEMER, ALA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
NEWMAN HODGE LAUGHLIN | | 14. MOTHER'S MAIDEN NAME
MINNIE LEE KIRK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES 6-12-41 10/13/67 | | 16. SOCIAL SECURITY NO.
4-10 24 0199 | |
| 17. INFORMANT WIFE
MAY LAUGHLIN, 5 TANNER AVE, LEXINGTON PK, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
ACUTE MYOCARDIAL INFARCTION
IMMEDIATE CAUSE (a) 4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11 OCT. 1967 , to 13 OCT. 1967 , that (I) (we) last saw the deceased alive on 13 OCT 1967 , and that death occurred at 9:28 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Jack E. Zimmerman | | 22b. DATE SIGNED
14 OCT 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
JACK E. ZIMMERMAN | | 22d. ADDRESS
NAVAL HOSPITAL, BETHESDA, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
10-17-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEMETERY, ARLINGTON, VIRGINIA | | 23d. LOCATION (City or Town) (County) (State) | |
| 25a. REC'D BY REGISTRAR
Robinson Funeral Home, Leonardtown, Maryland | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| DATE
OCT 23 1967 | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14138

FOR STATE HEALTH DEPT.

| | | | | | | | | | |
|--|---|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> c. LENGTH OF STAY IN 1b
<u>3 years</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>12704 Helen Road</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> <u>15-1</u>
d. STREET ADDRESS
<u>12704 Helen Road</u> e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Margaret</u> Middle <u>E.</u> Last <u>Ledford</u> | | | 4. DATE OF DEATH
Month <u>October</u> Day <u>3</u> Year <u>1967</u> | | | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 20, 1889</u> | 9. AGE (In years last birthday)
<u>77</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | |
| 13. FATHER'S NAME
<u>Jackson Wingate</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Laura Cashion</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>578-05-0676D</u> | | 17. INFORMANT
<u>Virginia Ramsay</u> <u>12704 Helen Road, Wheaton, Maryland</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>
4201 DUE TO (b) <u>Arteriosclerotic Heart Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour <u> </u> e.m. <u> </u> p.m. <u> </u> | Month, Day, Year
<u> </u> <u> </u> <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
<u>Belden R. Read</u>
EXAMINER'S NAME (Type)
<u>BELDEN R. READ, M.D.</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Wheaton</u>
Address (Street, city, town, or county) | | DATE SIGNED
<u>Oct. 3, 1967</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Oct. 6, 1967</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Cemetery</u> | | | | | |
| 22d. LOCATION (City, town, or country) (State)
<u>Prince Georges County, Md.</u> | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | |
| 23. GENERAL DIRECTOR'S SIGNATURE
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information on this certificate is not correct, please execute a new certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14134

CERTIFICATE OF DEATH

14139

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Virginia b. COUNTY Virginia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | c. LENGTH OF STAY IN 1b
4 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | e. STREET ADDRESS
2406 Fort Scott Drive | |
| 3. NAME OF DECEASED (Type or print)
First Ethel Middle Jeanne Davis Last LEGGETT | | 4. DATE OF DEATH
Month October Day 5 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 13, 1899 |
| 9. AGE (In years last birthday)
68 yrs. | | 10. IF UNDER 1 YEAR
Months 5 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 11. BIRTHPLACE (County & State, or foreign country)
Falls Church, Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Eugene Davis | | 14. MOTHER'S MAIDEN NAME
Blanch Gott | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
230 30 9107 | |
| 17. INFORMANT
Scott Drive, Arlington, Virginia | | 18. CAPT. Aubrey B. Leggett, USN, Ret. 2406 Fort | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral infarction, right
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 1 , 19 67 , to Oct. 5 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 5 , 19 67 , and that death occurred at 1105M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Lawrence W. Raymond</i> | | 22b. DATE SIGNED
Oct. 6 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Lawrence W. Raymond, M. D. | | 22d. ADDRESS
Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10-9-67 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia |
| 24. FUNERAL DIRECTOR
Pearsons Funeral Home | | 25a. RECEIVED BY REGISTRAR
1967 | |
| 472 North Washington St., Falls Church, Va. | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14134

11133

RECORDS OF THE

Virginia

Department

Arlington

4 days

Referrals (1961)

Gloucester County Drive

Legal Hospital

October

1960

James Davis

Edgar

March 15, 1961

James

James

USA

Police Court, Va.

VA

Howard

March 1961

James Davis

Gloucester County, Arlington, Virginia

250 30 3107

No

General Hospital, Virginia

Oct. 1

VA

Oct. 2

VA

VA

Lawrence W. Raymond, M.D.

James Davis, B.S.

Arlington National

Referral

James Davis, M.D.

Police Court, Va.

Arlington, Virginia

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14135

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14140

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE
MARYLAND
b. COUNTY
MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
OLNEY | | c. LENGTH OF STAY IN 1b
D.O.A. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
DAMASCUS |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MONTGOMERY GENERAL HOSPITAL | | d. STREET ADDRESS
25913 REVUE DRIVE | |
| 3. NAME OF DECEASED
(Type or print)
THOMAS MILLER LEISHEAR | | 4. DATE OF DEATH
Month 10 Day 30 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-12-99 |
| 9. AGE (In years lost birthday)
68 yrs. | | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY
FARMER | 11. BIRTHPLACE (State or foreign country)
MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
THOMAS MILLER LEISHEAR, SR. | |
| 14. MOTHER'S MAIDEN NAME
MARY FRANCES MOLESWORTH | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
577-26-9465A | | 17. INFORMANT
MEDICAL RECORD DEPT. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary Artery (Heart) Disease
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 20a. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20e. (City or town) | | 20f. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| 22. DATE SIGNED
10/30/1967 | | 23. REC'D BY REGISTRAR
NOV 2 1967 | |
| 24. FUNERAL DIRECTOR
Francis H. Barber Laytonsville, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
11-2-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Carmel | | 23d. LOCATION (City or Town) (County) (State)
Sunshine Mont. Md. | |

Body released p/o Dr. Rap

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FD-35-15

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14141

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
<u>Montgomery</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<u>MARYLAND</u>
b. COUNTY
<u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WHEATON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ROCKVILLE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>RANDOLPH HILLS NURSING HOME - 4011 Randolph Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>ANNA D. LELAND</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>MAY 17, 1879</u> |
| 9. AGE (In years last birthday)
<u>88</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>NEW YORK CITY</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Robert Ross</u> | | 14. MOTHER'S MAIDEN NAME
<u>Eleanor Duby</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>084-03-1367-D</u> | |
| 17. INFORMANT
<u>Harris D. Leland</u> | | 18. ADDRESS
<u>329 West Edmonston Dr. Rockville, Md.</u> | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>1530</u>
DUE TO (b) <u> </u>
DUE TO (c) <u>CARCINOMA OF THE CECUM 2 months</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | 20f. (City or town) (County) (State)
<u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 30, 1967</u> , to <u>OCT 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT 27, 1967</u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Benne G. Bendlar</u> | | 22b. DATE SIGNED
<u>10-31-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Benne G. Bendlar</u> | | 22d. ADDRESS
<u>10820 Georgia Ave Wheaton, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Trans-burial</u> | 23b. DATE THEREOF
<u>Nov. 2, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Evergreens Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Kings County New York</u> |
| 24. FUNERAL DIRECTOR
<u>C. Glen Carter</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Warner E. Pumphrey, Inc.</u> | | 25c. ADDRESS
<u>8434 Georgia Avenue Silver Spring, Md.</u> | |

Funeral Director: C. Glen Carter
Warner E. Pumphrey, Inc.

8434 Georgia Avenue
Silver Spring, Md.

NOV 3 1967
Charles Judge

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750-5210

1870

FOR STATE HEALTH DEPT

14137

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14142

| | | | |
|--|----------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>6 Mo.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Bethesda Silver Spring Nursing Home</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Ruth</u> | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>11</u> Year <u>1967</u> | |
| 5. SEX <u>Fe.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 8, 1882</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Sam Montanye</u> | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Son</u> | | Address <u>Amarillo, Tex.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>
<u>4201</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Cardio Vascular Disease</u>
DUE TO
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u>
<u>Years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>John G. Ball</u>
EXAMINER'S NAME (Type)
<u>JOHN G. BALL</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) <u>Bethesda, Md.</u> | |
| 22. DATE SIGNED
<u>10/11/67</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>10-13-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Glenwood Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D. C.</u> | |
| 24. FUNERAL DIRECTOR
<u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR
<u>OCT 16 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles J. ...</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health.

3111

JOHN A. BARNES, JR. (1910-1980)

1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14138

14143

| | | | | | | | |
|---|---|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery Co.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Washington</u> b. COUNTY <u>District of Columbia</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | c. LENGTH OF STAY IN 1b
<u>3 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>47-3</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Potomac Valley Nursing Home</u> | | | | d. STREET ADDRESS
<u>4709 Yuma St. N.W.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Charles</u> First Middle Last | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>24</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4/12/86</u> | 9. AGE (In years last birthday)
<u>81</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Economist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Gov't.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>New York, New York</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Harold Lund</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Marat</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes 1919</u> | | 16. SOCIAL SECURITY NO.
<u>- - - -</u> | | 17. INFORMANT
<u>Eleanor C. Lund</u> Address <u>4709 Yuma St. Washington, D.C.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u>
DUE TO (b) <u>CVA</u>
DUE TO (c) <u>Uremia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 10, 1964</u> to <u>Oct. 24, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct. 24, 1967</u> , and that death occurred at <u>12:45</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Robert A. Macon</u> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>10/24/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. Robert C. Macon,</u> | | | | 22d. ADDRESS
<u>809 Veirs Mill Road, Rockville, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal</u> | | 23b. DATE THEREOF
<u>10-27-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Greenwood Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Brooklyn, N.Y.</u> | |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 26 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

MEDICAL CERTIFICATION

14132

1113

UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

Geological Survey

W. H. Murray, Jr.
Geologist
U. S. Geological Survey
Washington, D. C.
1913

Report of the
Geological Survey
of the
United States
for the year
1913

14138

CERTIFICATE OF DEATH

14144

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | c. LENGTH OF STAY IN lb
28 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | d. STREET ADDRESS
9005 Colesville Road | |
| 3. NAME OF DECEASED (Type or print) John Joseph LUSBY | | 4. DATE OF DEATH
Month Oct. Day 12 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 4, 1901 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U. S. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) yrs. 66 |
| 11. BIRTHPLACE (County & State, or foreign country)
Montgomery Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George Lowther Lusby | | 14. MOTHER'S MAIDEN NAME
Estella Windham | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1919-1948 | | 16. SOCIAL SECURITY NO. 579-18-9723 | |
| 17. INFORMANT Rd., Silver Spring, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, Left Upper Lobe
DUE TO (b) Chronic Lymphocytic leukemia
DUE TO (c) 2040
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 14 , 19 67 , to Oct. 12 , 19 67 , that (I) (we) last saw the deceased alive on Oct. 12 , 19 67 , and that death occurred at 145A M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<i>David L. Foreman</i> | | 22b. DATE SIGNED
Oct. 13, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
David L. Foreman | | 22d. ADDRESS
Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Oct. 17, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia |
| 24. FUNERAL DIRECTOR
<i>Glen Carter</i> Warner E. Pumphrey Funeral Home | | 25a. REC'D BY REGISTRAR
OCT 19 1967 | 25b. REGISTRAR'S SIGNATURE
<i>Glen Carter</i> |
| 24. FUNERAL DIRECTOR ADDRESS
8434 Georgia Ave., Silver Spring, Md. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14132

UNITED STATES OF AMERICA

14141

1. Name

Belmont (Mrs.)

2. Age

3. Sex

4. Occupation

5. Address

6. Date

7. Time

8. Cause

9. Effect

10. Remarks

11. Signature

12. Date

13. Time

14. Name

15. Address

16. Date

17. Time

18. Remarks

19. Name

20. Address

21. Date

22. Time

23. Remarks

24. Name

25. Address

26. Date

27. Time

28. Remarks

29. Signature

14140

CERTIFICATE OF DEATH

14145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Chas. W. Rupp called - Cleared

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b
<u>42 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | d. STREET ADDRESS
<u>4201 Massachusetts Ave. NW</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>ALICE L. LYONS</u> | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>25</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Apr. 15-1891</u> |
| 9. AGE (In years last birthday)
<u>76</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 12. BIRTHPLACE (County & State, or foreign country)
<u>Boston, Massachusetts</u> | | 13. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 14. FATHER'S NAME
<u>Michael Cummings</u> | | 15. MOTHER'S MAIDEN NAME
<u>Brigid Joyce Cummings</u> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT
<u>Mr. Arthur V. Dieli, 2020 Hanover St.</u> | | 19. ADDRESS
<u>Silver Spring, Md.</u> | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>4500 Congestive heart failure</u>
DUE TO (b) <u>ATHEROSclerosis</u>
DUE TO (c) <u>Age</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Fracture RT wrist & THIP</u> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
<u>PT fell down stairs</u> | |
| 22a. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 22b. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work | 22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | 22d. (City or town) (County) (State)
<u>Washington D.C.</u> <u>Montgomery</u> <u>D.C.</u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-13-67</u> , 19 <u>67</u> , to <u>10-25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-24</u> , 19 <u>67</u> , and that death occurred at <u>8:35 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Henry William Jaeger</u> | | 22b. DATE SIGNED
<u>10-25-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Henry W. Jaeger</u> | | 22d. ADDRESS
<u>1015 Spring St., Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>10-28-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Seaside Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Lanesville, Massachusetts</u> |
| 24. FUNERAL DIRECTOR
<u>Rinaldi Funeral Home, 7400 Georgia Ave, NW</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE <u>OCT 31 1967</u> | |

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REPUBLIC OF THE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18&21 Film 395

MARYLAND STATE DEPARTMENT OF HEALTH

11-20-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14146

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TAKOMA PARK | | c. LENGTH OF STAY IN 1b
1 DAY | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
WASHINGTON SAN & Hosp. | | d. STREET ADDRESS
FAIRLAND NURSING HOME | |
| 3. NAME OF DECEASED
(Type or print)
CLARENCE LEROY MAISACK | | 4. DATE OF DEATH
OCT. 21 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. AGE (In years lost birthday)
73 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED TRACKMAN | | 10b. KIND OF BUSINESS OR INDUSTRY
PRIVATE UTILITY | |
| 11. BIRTHPLACE (State or foreign country)
HAGERSTOWN, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JACOB F. MAISACK | | 14. MOTHER'S MAIDEN NAME
MAMIE ENGLEBRIGHT | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
219-54-2258 | |
| 17. INFORMANT
Hosp. Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a) Acute coronary insufficiency
DUE TO (b) Coronary artery heart disease
OUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22. OATE SIGNED
Belden R. Yeap M.D.
10/21/1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | 23b. OATE THEREOF
10/24-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON 23, D. C. | |
| 24. FUNERAL DIRECTOR
CHARLES M. ROUZER, HAGERSTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
OCT 30 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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— *Journal of the American Medical Association*

2

CERTIFICATE OF DEATH

14142

14147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|---|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE D. C. b. COUNTY --- | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Carroll Hall Sanitarium | | | | d. STREET ADDRESS
638 A St., NE | | | |
| 3. NAME OF DECEASED (Type or print)
First BERTRAM Middle MAJOR Last MAJOR | | | | 4. DATE OF DEATH
Month OCTOBER Day 11 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 7, 1891 | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. | IF UNDER 24 HRS.
Hours 0 Min. | 10. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired-Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Navy Yard | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Major | | | | 14. MOTHER'S MAIDEN NAME
Annie Grimes | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
548-50-0489 | | 17. INFORMANT
Mrs. Dorothy Hoover, Wantagh, LI, NY | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS
DUE TO CHRONIC MYOCARDITIS
DUE TO GENERALIZED ARTERIOSCLEROSIS
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
CEREBRAL SCLEROSIS | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
12 HOURS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from JAN. 26, 1967 to OCTOBER 11, 1967 , that (I) (we) last saw the deceased alive on OCTOBER 11, 1967 , and that death occurred at 4:30 M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Henry J. Landon</i> | | | | 22b. DATE SIGNED
10-11-67 | | 22c. PHYSICIAN'S NAME (Type)
Henry J. Landon | |
| 22d. ADDRESS
5206 Norway Dr. Chevy Chase, Md. | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10/13/67 | 23c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | 23d. LOCATION (City, town or county) | (State)
D.C. | | | |
| 24. FUNERAL DIRECTOR
J. Wm. Lees Sons; Washington, DC | | | | 25a. REC'D BY REGISTRAR
OCT 16 1967 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>2 MONTHS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | d. STREET ADDRESS <u>13508 Crispin Way</u> | |
| 3. NAME OF DECEASED (Type or print) <u>William J. Mancusi</u> | | 4. DATE OF DEATH <u>October 19, 1967</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/17/23</u> |
| 9. AGE (In years last birthday) <u>44</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Representative</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Philip Mancusi</u> | | 14. MOTHER'S MAIDEN NAME <u>Ada Conklin</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Navy - WWII</u> | | 16. SOCIAL SECURITY NO. <u>065-12-0800</u> | |
| 17. INFORMANT <u>MRS. JOAN Mancusi</u> | | Address <u>13508 Crispin Way Rockville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Brain & Stem Compression</u>
DUE TO <u>due to Malignant</u>
DUE TO <u>Glioma of Brain of Brain (malignant glioma)</u>
(c) <u>6.2.55</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 1967</u> to <u>Oct 19, 1967</u> that (I) (we) last saw the deceased alive on <u>Oct 18, 1967</u> and that death occurred at <u>6:40 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John Thomas Head</u> | | 22b. DATE SIGNED <u>10/19/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>John Thomas Head</u> | | 22d. ADDRESS <u>1015 Spring St Silver Spring, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>10/23/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville, Pike</u> | | 25. REC'D BY REGISTRAR <u>OCT 23 1967</u> | |
| 25a. REGISTRAR'S SIGNATURE <u>William J. Mancusi</u> | | 25b. REGISTRAR'S SIGNATURE <u>William J. Mancusi</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | |
| c. LENGTH OF STAY IN 1b <u>3 hours 45 min</u> | | d. STREET ADDRESS <u>2600 Queens Chapel Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Sam</u> First <u>(None)</u> Middle <u>Mandel</u> Last | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/2/21</u> |
| 9. AGE (In years last birthday) <u>46</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housing Urban Development U.S. govt</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Mandel</u> | | 14. MOTHER'S MAIDEN NAME <u>?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army Sgt-2</u> | | 16. SOCIAL SECURITY NO. <u>052-128845</u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address <u>7600 Carroll Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Acute Myocardial Infarction</u>
(c) <u>Coronary Sclerosis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Myocardial Infarction in 1965</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1967, to <u>10/22</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/20</u> 1967, and that death occurred at <u>4:52 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Samuel Dessoff</u> | | 22b. DATE SIGNED <u>10/22/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>SAMUEL DESSOFF</u> | | 22d. ADDRESS <u>1302-18 ST. N.W. WASH. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>OCT 27, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEM</u> | 23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u> |
| 24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |
| ADDRESS <u>Riverdale, Md.</u> | | DATE <u>OCT 27 1967</u> | |

1-11-13

UNITED STATES DEPARTMENT OF THE INTERIOR

10114

George Washington

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "George Washington" and "Department of the Interior" are faintly visible.]

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250
OCT 10 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

14145

CERTIFICATE OF DEATH

14150

| | | | | | | | |
|---|----------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Chest Chase</u> | | c. LENGTH OF STAY IN lb
<u>26 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Chest Chase, Md.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>3713 Williams Lane</u> | | | | d. STREET ADDRESS
<u>3713 Williams Lane</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>INHERBER</u> First Middle Last <u>Mary</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 3 1899</u> | 9. AGE (In years last birthday) <u>68</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>At Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Fritz Papendieck</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Toni Papendieck</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>579-44-7563</u> | | 17. INFORMANT
<u>Fritz Karl Mann</u> | | Address <u>3713 Williams LA. Ch Ch. Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>LIVER Failure</u>
<u>1538</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Carcinoma of Colon</u>
DUE TO
(c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 mo.</u>
<u>2 1/2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>None</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>10/8</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>67</u> and that death occurred at <u>5 A</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Edgar H. Levin</u> M.D. | | | | 22b. DATE SIGNED
<u>10/8/67</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>EDGAR H. LEVIN</u> | |
| 22d. ADDRESS
<u>8218 Wisconsin, Bethesda, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>10-11-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D. C.</u> | |
| 24. FUNERAL DIRECTOR
<u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 16 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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ORIGINAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 14145 | | | | | | | | | | | | | |
| 14151 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | | | c. LENGTH OF STAY IN 1b
15 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Riverdale | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington Sanitarium and Hospital | | | | | | d. STREET ADDRESS
4310 Queensbury Road | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Max John Mathews | | | | | | 4. DATE OF DEATH
Month October Day 31 Year 1967 | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3-2-11 | | 9. AGE (In years last birthday)
56 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Real Estate Salesman | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Utah | | | | 12. CITIZEN OF WHAT COUNTRY?
America | | | |
| 13. FATHER'S NAME
Thomas Mathews | | | | | | 14. MOTHER'S MAIDEN NAME
Margaret Griffiths | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
578-28-8494 | | 17. INFORMANT
Patinet's chart Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Neurologic Disease, Echology Unclt.
355X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic Urinary Tract Infection | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-15 , 19 67 , to 10-31 , 19 67 , that (I) (we) last saw the deceased alive on 10-30 19 67 , and that death occurred at 6:10 A.M., from causes and on the date stated above | | | | | | | | | | | | | |
| 22a. SIGNATURE
George M. Grames M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
Oct 31, 1967 | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
George M. Grames | | | | | | 22d. ADDRESS
hospital Takoma Park, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Nov 3, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Maple Grove Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Farmer City Illinois | | | | | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons | | | | | | ADDRESS
Hyattsville, Md. | | 25a. REC'D BY REGISTRAR
DATE NOV 2 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

14147

14152

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE WEST VIRGINIA b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
OLNEY | | c. LENGTH OF STAY IN 1b
DOA | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LOOKOUT |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MONTGOMERY GENERAL HOSPITAL | | d. STREET ADDRESS
- | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
RUSSELL (NMN) McCLELLAND | | 4. DATE OF DEATH
Month Day Year
10 18 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-2-16 |
| 9. AGE (In years last birthday) yrs.
51 | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CARPENTER | | 10b. KIND OF BUSINESS OR INDUSTRY
RETIRED | 11. BIRTHPLACE (State or foreign country)
BROOKLYN, WEST VIRGINIA |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
ALONZO McCLELLAND | |
| 14. MOTHER'S MAIDEN NAME
ELLA COPELAND | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MEDICAL RECORD DEPT. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Coronary Artery Heart Disease
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Belden R. Reap, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) BELDEN R. REAP, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED
10/18/1967 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | 23b. DATE THEREOF
Oct. 19 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Wallace Memorial | 23d. LOCATION (City or Town) (County) (State)
Clintonville West Virgin |
| 24. FUNERAL DIRECTOR
Francis H. Barber Laytonville Md. | | 25a. REC'D BY REGISTRAR
OCT 23 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

1-11-52

MEDICAL RECORDS DEPARTMENT

1-11-52

DATE RECEIVED

DATE RECEIVED

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Handwritten notes and signatures in the center of the page.

of 19 1957 Wallace Memorial
Clintonville West Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G39J 11/1/67 ph

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CLARKSBURG | c. LENGTH OF STAY IN 1b
>10 YRS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CLARKSBURG MD | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
RT #1 Box 129, | | d. STREET ADDRESS
RT #1 Box 129 | |
| 3. NAME OF DECEASED
(Type or print)
First HERMAN Middle FOSTER Last MCDONALD | | 4. DATE OF DEATH
Month 10 Day 19 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
N | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/25/06 |
| 9. AGE (In years lost birthday)
60 6/11 yrs. | | IF UNDER 1 YEAR
Months 6 Days 11 Hours 11 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MAINTENANCE WK. STATE ROADS | | 10b. KIND OF BUSINESS OR INDUSTRY
MAINTENANCE WK. STATE ROADS | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Clarence McDonald | | 14. MOTHER'S MAIDEN NAME
Julia Clipper | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Matilda McDONALD CLARKSBURG MD | | Address RT #1 Box 129 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic CARDIOVASCULAR disease
DUE TO
(c) 10 YRS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Nephrosclerosis | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
MINUTES | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8/10 , 19 67 , to 10/15 , 19 67 , that (I) (we) last saw the deceased alive on 10/15 , 19 67 , and that death occurred at 8 P.M. , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Melvin J. Kordon | | 22b. DATE SIGNED
10/19/67 | |
| 22c. PHYSICIAN'S NAME (Type)
MELVIN JOEL KORDON MD | | 22d. ADDRESS
13 DEER PARK DR, GAITHERSBURG MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
10/22/67 | 23c. NAME OF CEMETERY OR CREMATORY
Sugarland Cem. | 23d. LOCATION (City or Town) (County) (State)
Sugarland Montg. Md. |
| 24. FUNERAL DIRECTOR
Robert L. Suorden Rockville, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 26 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | |

2000

14148

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Washington, D.C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington, D.C.</u> | |
| c. LENGTH OF STAY IN 1b
<u>14 Days</u> | | d. STREET ADDRESS
<u>1316 Van Buren Street, N.W.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Maryland</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mamie</u> Middle <u>Marie</u> Last <u>McGill</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>14</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>15 October 1914</u> |
| 9. AGE (In years last birthday)
<u>52</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Shipper</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY
<u>--</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>George Thomas Bowe</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Lessie Arnold</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | |
| 16. SOCIAL SECURITY NO.
<u>181-22-5077</u> | | 17. INFORMANT
<u>The Medical Records</u>
<u>The Clinical Center, Bethesda, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute systemic vasculitis</u>
DUE TO
(b) <u>Acute Myocardial infarction</u>
DUE TO
(c) <u>Sjogren's syndrome</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. <u>19</u>
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>30 Sept.</u> , 19 <u>67</u> , to <u>14 Oct.</u> , 19 <u>67</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>14 October</u> 19 <u>67</u> , and that death occurred at <u>9:00 M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>J. T. Willerson</u> | | 22b. DATE SIGNED
<u>14 October 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>James T. Willerson, MD.</u> | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/> | 23b. DATE THEREOF
<u>10-18-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Restland Mem. Park</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Wilmerding, Pa. Allegheny County</u> |
| 24. FUNERAL DIRECTOR
<u>Stewart Funeral Home 4001 Benning Rd.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 17 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1944

UNITED STATES OF AMERICA

1944

IN SENATE, January 11, 1944.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

ON THE LANDS OF THE UNITED STATES IN THE TERRITORY OF ALASKA

FOR THE YEAR 1943

ALBANY, NEW YORK: 1944

U. S. GOVERNMENT PRINTING OFFICE

WASHINGTON: 1944

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14150

CERTIFICATE OF DEATH

14155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE VIRGINIA b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN lb
1 MONTH | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANNANDALE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Bethesda Naval Hospital | | | | d. STREET ADDRESS
7719 ARLEN STREET | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Martha Middle Lea Last MCGLADE | | | | 4. DATE OF DEATH
Month OCTOBER Day 31 Year 19 67 | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
CAUC. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
26 Sept 1926 | | 9. AGE (In years last birthday) yrs.
41 | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
NONE | | 11. BIRTHPLACE (County & State, or foreign country)
ORLANDO, FLORIDA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
RUPERT WILLIS | | | | 14. MOTHER'S MAIDEN NAME
ALICE VEAZY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (HUSBAND)
LAWRENCE MCGLADE, SAME AS #2 Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory and Cardiac Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Carcinomatosis
DUE TO
(c) Adenocarcinoma of Stomach | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from OCT 2, 1967 , to OCT 31, 1967 , that (I) (we) last saw the deceased alive on 31 OCTOBER 1967 , and that death occurred on 1:50 AM , from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Charles S. Crummy</i> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
OCT 31, 67 | |
| 22c. PHYSICIAN'S NAME (Type)
Charles S. CRUMMY, M.D. | | | | 22d. ADDRESS
NAVAL HOSPITAL, BETHESDA, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (specify)
BURIAL | | 23b. DATE THEREOF
11/1/67 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEM. | | 23d. LOCATION (City or Town) (County) (State)
ARLINGTON, VIRGINIA | |
| 24. FUNERAL DIRECTOR
<i>John R. Brown</i>
ARLINGTON FUNERAL HOME | | | | ADDRESS
3901 FAIRFAX DR. ARLINGTON, VA. | | 25a. REC'D BY REGISTRAR
NOV 2 1967 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

14133

DEPARTMENT OF DEFENSE

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CERTIFICATE OF DEATH

14156

14151

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|--|----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN lb
3 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ashton | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montgomery General Hospital | | | | d. STREET ADDRESS
18820 New Hampshire Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Arthur Last McGrath | | | | 4. DATE OF DEATH
Month October Day 10 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
Dec. 5, 1919 | | 9. AGE (In years last birthday) yrs. 47 | IF UNDER 1 YEAR
Months 15 Days 1 Hours 1 Min. | IF UNDER 24 HRS.
Hours 1 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lawyer | | 10b. KIND OF BUSINESS OR INDUSTRY
Lawyer | | 11. BIRTHPLACE (County & State, or foreign country)
Minnesota | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Thomas McGrath | | | | 14. MOTHER'S MAIDEN NAME
Lucy Kelly | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO.
186-10-4789 | | 17. INFORMANT
Medical Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO (b) Myocardial Infarction
DUE TO (c) Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 hrs.
months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic Pancreatitis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1955 , 19 Oct 10 , 19 67 , that (I) (we) last saw the deceased alive on 10/10 19 67 , and that death occurred at 6:55 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Richard A. Yates, M.D. | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10/10/67 | |
| 22c. PHYSICIAN'S NAME (Type) Richard A. Yates, M.D. | | | | 22d. ADDRESS
Old Baltimore Road, Olney, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-13-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
OCT 16 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>35 days</i> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i> | | d. STREET ADDRESS <i>3703 Calvert Place</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <i>William Thomas McKenna</i> | | 4. DATE OF DEATH
Month <i>October</i> Day <i>19</i> Year <i>1967</i> | |
| 5. SEX <i>male</i> | | 6. COLOR OR RACE <i>white</i> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>3/21/04</i> | |
| 9. AGE (In years last birthday) <i>63</i> yrs. | | IF UNDER 1 YEAR
Months <i></i> Days <i></i> Hours <i></i> Min. <i></i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired (Attorney)</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Veterans Administration - Langhorne</i> | |
| 11. BIRTHPLACE (County & State or foreign country) <i>USA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>William James McKenna</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Enright</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> <i>1942-1945</i> | | 16. SOCIAL SECURITY NO. <i>577-03-6200</i> | |
| 17. INFORMANT <i>Mary McKenna - (sister)</i> | | Address <i>3703 Calvert Place</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>
DUE TO (b) <i>ca larynx</i>
DUE TO (c) <i></i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>
INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>
<i>3 yrs</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <i></i> a.m. <i></i> p.m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1/5/67</i> , 19 <i>67</i> to <i>10/19</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>10/19</i> , 1967, and that death occurred at <i>8:45 PM</i> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Patrick C. Jameson</i> M.D. | | 22b. DATE SIGNED <i>10/20/67</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>Patrick C. Jameson</i> | | 22d. ADDRESS <i>11718 Ga Ave Silver Spring Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>10-24-67</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Md.</i> | |
| 24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | 25a. REC'D BY REGISTRAR <i>DATE OCT 25 1967</i> | |
| 25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i> | | | |

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1943-5-11-13 for the same - 3703 Cash
 William James the same they brought
 3/21/04 63
 The same - 3703 Cash
 1943-5-11-13 for the same - 3703 Cash
 William James the same they brought
 3/21/04 63
 The same - 3703 Cash
 1943-5-11-13 for the same - 3703 Cash
 William James the same they brought
 3/21/04 63
 The same - 3703 Cash

1943-5-11-13 for the same - 3703 Cash
 William James the same they brought
 3/21/04 63
 The same - 3703 Cash
 1943-5-11-13 for the same - 3703 Cash
 William James the same they brought
 3/21/04 63
 The same - 3703 Cash

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14153

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2a,c & d Film #301 11/13/67 ph

CERTIFICATE OF DEATH

14158

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Va.</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>KENSINGTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fort Belvoir</u> | |
| c. LENGTH OF STAY IN <u>1 Mo. 8 days</u> | | d. STREET ADDRESS
<u>1718 Kimbro Loop C-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>KENSINGTON GARDENS SANITARIUM</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>BRIGETTE F McLEOD</u> | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>29</u> Year <u>1967</u> | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>COLORED</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>DEC 4 - 1947</u> |
| 9. AGE (In years last birthday)
<u>19</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>1</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Germany</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Germany</u> | |
| 13. FATHER'S NAME
<u>Fritz Kock</u> | | 14. MOTHER'S MAIDEN NAME
<u>Henni Reubert</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>20</u> | |
| 17. INFORMANT
<u>Sgt. Charles McLeod</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pneumonia - terminal</u>
DUE TO <u>diffuse encephalopathy</u>
DUE TO <u>anoxia - cardiac arrest</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u>
<u>?</u>
<u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>0</u> a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 24, 1967</u> , to <u>Oct 29, 1967</u> , that (I) (we) lost saw the deceased alive on <u>10/27 1967</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | 22b. DATE SIGNED
<u>10/29/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>H F Kreuzburg</u> | | 22d. ADDRESS
<u>7852 16th Ave NW Wash DC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Nov 3, 1967</u> | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Port Meyer, Virginia</u> |
| 24. FUNERAL DIRECTOR
<u>Frozewer Funeral Home, Inc. Ave. NW</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

2003

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

| <div>14154</div> <div>909pm</div> <div>14159</div> | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>Don</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> | | | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | | | | | d. STREET ADDRESS <u>9320 Blue Road</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Paige T. Medairy</u> | | | | | | 4. DATE OF DEATH <u>Oct 17 1967</u> | | Month <u>17</u> Day <u>19</u> Year <u>67</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 6 1922</u> | | 9. AGE (In years last birthday) <u>45</u> yrs. | | IF UNDER 1 YEAR: Months <u>11</u> Days <u>10</u> Hours <u>15</u> Min. <u>00</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plum Foreman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Edmund Medairy</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Waisy Perrell</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>U.S. Army</u> | | | | 16. SOCIAL SECURITY NO. <u>214-16-1275</u> | | 17. INFORMANT <u>Jeannette Medairy</u> Address <u>same as above</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>
DUE TO (b) <u>Sudden</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED <u>10/17/67</u> | | | |
| EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Oct. 21, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Damascus, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>OCT 23 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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14155

CERTIFICATE OF DEATH

14160

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda Rural | | c. LENGTH OF STAY IN lb
2 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | d. STREET ADDRESS
10500 Rockville Pike | |
| 3. NAME OF DECEASED (Type or print) Kenmore E. MERRIAM | | 4. DATE OF DEATH
Month Oct Day 18 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb 1, 1903 |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR
Months 15 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U. S. NAVY | | 10b. KIND OF BUSINESS OR INDUSTRY
Armed Forces | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert Merriam | | 14. MOTHER'S MAIDEN NAME
FLORENCE MILLER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes W.W.II | | 16. SOCIAL SECURITY NO.
561 54 9596 | |
| 17. INFORMANT
Mary Merriam | | Address
10500 Rockville Pike, Rockville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201 Myocardial infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) DUE TO
(c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 16 Oct. , 19 67 , to 18 Oct. , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 18 Oct. 19 67 , and that death occurred at 8:42 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Robert J. Kinney | | 22b. DATE SIGNED
20 October 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Robert J. Kinney, M. D. | | 22d. ADDRESS
Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/23/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington Va. | |
| 24. FUNERAL DIRECTOR
Jos. Gawler & Sons | | 25a. REC'D BY REGISTRAR
DATE OCT 29 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

622

YOUNG, T. U.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| | | | | | | | | | | | |
|---|--|------------------------|--|---|--|--|--|---|------------------------------|---|--|
| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 14156 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 14161 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN HOSPITAL | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE VIRGINIA
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH
d. STREET ADDRESS 6166 LEESBURG PIKE
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) JACOB J. MICHAELSON | | | | | | 4. DATE OF DEATH
Month October Day 11 Year 1967 | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
NOV. 27, 1927 | | 9. AGE (In years last birthday) 39 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRUG STORE CLERK | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) NEW YORK | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME
SOL MICHAELSON | | | | | | 14. MOTHER'S MAIDEN NAME
SONIA BLUMENTHAL | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) YES KOREA | | | | 16. SOCIAL SECURITY NO. 234 32 6227 | | 17. INFORMANT WIFE
MRS. MARSHIA MICHAELSON-AS ABOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Coronary Artery Disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept, 1966, to Oct 10, 1967, that (I)(we) last saw the deceased alive on Oct 10, 1967, and that death occurred at 2:00 M, from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Richard H. Edenbaum M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED
10/11/67 | | |
| 22c. PHYSICIAN'S NAME (Type)
Richard H. Edenbaum MD | | | | | | 22d. ADDRESS
4700 Bradley Blvd. Ch. Ch. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE THEREOF
10-13-67 | | 23c. NAME OF CEMETERY OR CREMATORY
NATIONAL CAPITAL HEBREW CEM. | | | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON, DC | |
| 24. FUNERAL DIRECTOR
BERNARD DANZANSKY & SONS | | | | | | ADDRESS
WASHINGTON DC | | 25a. REC'D BY REGISTRAR
DATE OCT 16 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1415

MONTGOMERY

SEBASTIAN

SUBURBAN HOSPITAL

JACOB D.

MALE WHITE

DRUG STORE CLERK

SON MICHAELSON

YES KOREAN

VIRGINIA

ELITE CANTON

8132 LEBRON BLVD

MICHAELSON

NOV. 27, 1957 39

NEW YORK

LOUISA BLUMENFELD

WIFE

October 11, 1957

USA

10-1-57 NATIONAL CAPITAL HEALTH CENTER
BIRMINGHAM 2-2000

14157

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|-------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b <i>4 hours</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i> | | d. STREET ADDRESS <i>5415 Glenwood Road</i> | |
| 3. NAME OF DECEASED
(Type or print) <i>Charles - Russell-Miller</i> | | 4. DATE OF DEATH
Month <i>October</i> Day <i>19</i> Year <i>1967</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8/22/04</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Charles S. Miller Co.</i> | |
| 11. BIRTHPLACE (County & State, or foreign country) <i>Detroit - Michigan</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Harry Albert Miller</i> | | 14. MOTHER'S MAIDEN NAME <i>Leona E. Miller</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>5415 Glenwood</i> | |
| 17. INFORMANT <i>Mrs. C. Miller</i> | | Address <i>5415 Glenwood</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cachexia</i>
DUE TO (b) <i>Metastatic reticulum cell lymphoma</i>
DUE TO (c) <i>lymphoma</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
<i>10 months</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <i>none</i> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <i>a.m.</i> <i>19</i> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Feb 21, 1967</i> to <i>Oct 17, 1967</i> , that (I) (we) last saw the deceased alive on <i>Oct 17, 1967</i> , and that death occurred at <i>9:22 PM</i> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Allen J. O'Neill</i> | | 22b. DATE SIGNED <i>Oct 19, 1967</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill MD</i> | | 22d. ADDRESS <i>8601 Old George Town Rd</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>10-24-67</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i> | |
| 24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | 25a. REC'D BY REGISTRAR <i>OCT 25 1967</i> | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i> | | | |

Handwritten notes, possibly a list or index, including names and dates. The text is mirrored across the page.

Handwritten notes, possibly a list or index, including names and dates. The text is mirrored across the page.

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Handwritten notes, possibly a list or index, including names and dates. The text is mirrored across the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

CLEARER BY MEDICAL EXAMINER

| | | | | | | | | | | | | | |
|--|--|---------------------------|---|--|---|---|--|---|-------|---|--|---|--|
| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| 14158 | | | | | | CERTIFICATE OF DEATH | | | 14164 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | | | c. LENGTH OF STAY IN lb
<u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> 15.1 | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>HOLY CROSS</u> | | | | | | d. STREET ADDRESS
<u>8508 16th ST.</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>JOHN D MORAN</u> | | | | | | 4. DATE OF DEATH
Month <u>OCT</u> Day <u>8</u> Year <u>1967</u> | | | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>June 19-80</u> | | 9. AGE (In years last birthday)
<u>87</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Engineer St. Mary City of N.Y.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>IRELAND</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>Daniel Moran</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Cinkben</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | | | 16. SOCIAL SECURITY NO.
<u>095-38-0626</u> | | 17. INFORMANT
<u>Hosp Records</u> | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>
DUE TO (b) <u>arterio-sclerotic Heart Disease</u>
DUE TO (c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>FRACTURE LEFT HUMERUS 9-28-67.</u> | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
ot work <input type="checkbox"/> ot work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-28, 1967</u> to <u>Oct 8, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Oct 8, 1967</u> , and that death occurred at <u>9:50 AM</u> , from causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Robert Kramer</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>10-8-67</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Robert Kramer</u> | | | | | | 22d. ADDRESS
<u>8484 16th ST. SS. MD</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
<u>Oct. 11, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Hawthorne, N.Y.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc.</u> | | | | | | ADDRESS
<u>8434-GA Ave Silver Spring, Md</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 10 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

98524

9. 10. 1991. 10. 10. 1991. 10. 10. 1991.

2000 年 12 月 10 日

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #2c & d Film #G393 10/23/67 ph

CERTIFICATE OF DEATH

14153

14163

| | | | | | |
|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b
<u>2+ yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> Kensington | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Althea Woodland Nsg. Home 1000 Oakview Dr.</u> | | | d. STREET ADDRESS
<u>4416 Clearbrook Lane</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Florence</u> Middle <u>M.</u> Last <u>Morrow</u> | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>14</u> Year <u>1967</u> | | |
| 5. SEX
<u>Fe</u> | 6. COLOR OR RACE
<u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-30-1877</u> | 9. AGE (In years last birthday)
<u>90</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Monmouth, Illinois</u> | |
| 13. FATHER'S NAME
<u>Jacob Morningstar</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Strahorn</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u>
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>-</u> | | 17. INFORMANT
<u>Beverly Greenley 511 Houston Ave TR, PK.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma, Uterine</u>
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 11, 1965</u> , to <u>Oct 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>10-13, 1967</u> , and that death occurred at <u>2:28 PM</u> , from causes on and the date stated above. | | | | | |
| 22a. SIGNATURE
<u>Bernard A. Fitzgerald</u> | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>10-14-67</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>BERNARD A FITZGERALD</u> | | | 22d. ADDRESS
<u>217 W. BLVD E, SIL. SP, MD</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | 23b. DATE THEREOF
<u>10/16/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lees Crematory</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington D.C.</u> | |
| 24. FUNERAL DIRECTOR
<u>J. Wm. Lees Sons, 300 4th St. NE, Wash., DC</u> | | | 25a. REC'D BY REGISTRAR
<u>OCT 17 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

10183

CERTIFICATE OF DEATH

10183

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

CERTIFICATE OF DEATH

14165

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS Route #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First Donald Middle Bennett Last Mullendore
4. DATE OF DEATH Month October Day 15 Year 1967
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 27 October 1898 9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant 10b. KIND OF BUSINESS OR INDUSTRY Manufacturing 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Edward C. Mullendore 14. MOTHER'S MAIDEN NAME Laura B. Lewis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 214-09-8122 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolus
DUE TO (b) Stem cell lymphoma
DUE TO (c) Chronic lymphocytic leukemia
INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 5 years
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While ☐ Not While ☐ at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that ☒ (this hospital) attended the deceased from Sept. 23, 1967, to Oct. 15, 1967, that ☒ (we) last saw the deceased alive on Oct. 15, 1967, and that death occurred at 7:40 M. from causes and on the date stated above.
22a. SIGNATURE Paul P. Carbone M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ 22b. DATE SIGNED 16 Oct. 1967
22c. PHYSICIAN'S NAME (Type) Paul P. Carbone, M.D. 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10-18-67 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. 25a. REC'D BY REGISTRAR John H. Bast, Jr. 25b. REGISTRAR'S SIGNATURE John H. Bast, Jr. DATE OCT 20 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-10-1907

CERTIFICATE OF DEATH

1-10-1907

NO. 1000

DECEASED

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF WITNESS

SIGNATURE OF DECEASED

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CERTIFICATE OF DEATH

14161

14166

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|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>Westmoreland</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensale</u> | |
| c. LENGTH OF STAY IN 1b <u>27 days</u> | | d. STREET ADDRESS <u>Rt 1 Box 31</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>George W. Mullins</u>
First Middle Last | | 4. DATE OF DEATH <u>10 21 1967</u>
Month Day Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-23-96</u>
yrs. |
| 9. AGE (In years lost birthday) <u>71</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>George Henry</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Sarah Anne Lendrum</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW I Army</u> | |
| 16. SOCIAL SECURITY NO. <u>449 03 9530</u> | | 17. INFORMANT <u>Mary Mullins alone</u>
Address <u>same as</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Right hemiplegia with global aphasia</u>
DUE TO <u>Cerebrovascular thrombosis</u>
DUE TO <u>Cerebrovascular sclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>29 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 25, 1967</u> , to <u>Oct 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 21, 1967</u> , and that death occurred at <u>10:30 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Stewart Clapp M.D.</u> | | 22b. DATE SIGNED <u>Oct 21 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u> | | 22d. ADDRESS <u>4740 Chevy Chase Dr</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Oct. 25-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Simmons Bros</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>Simmons Bros. - 1661 - Good Hope Rd SE Wash DC</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>OCT 24 1967</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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THE HOUSE OF DEBIL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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|--|--|-------------------------------|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 14162 | | | | Item #4 Film #G394 10/30/67 ph | | | | 14167 | | | | | | | |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u>
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u>
b. COUNTY <u>Montgomery</u> | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN lb <u>8 mos.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | 15-1 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u> | | | | d. STREET ADDRESS <u>510 University Blvd E.</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Marjaret Antoinette Myers</u> | | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>19</u> Year <u>1967</u> | | | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH <u>10-26-10</u> | | 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>N.J.K.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | | | | | |
| 13. FATHER'S NAME <u>Joseph Holland</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Fannie Baggott</u> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>yes</u> | | 17. INFORMANT <u>James H. Myers</u> | | Address <u>510 Univ. Blvd East Silver Spring, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Malnutrition, inanitia</u>
1538
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Carcinoma of colon c metastases</u>
DUE TO
(c) <u></u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>Oct. 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 18</u> , 19 <u>67</u> , and that death occurred at <u>9:30 A.M.</u> from causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Mar Schneider</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>10/19/67</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Marvin Schneider</u> | | | | 22d. ADDRESS <u>911 Silver Spring Ave.</u> | | | | | | | | | | | |
| 23a. BURIAL-CREMATATION REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>Oct 23, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Hyattsville Maryland</u> | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Carter E. Pumphrey, Inc.</u> | | | | | | ADDRESS <u>8434-Ga. Ave. S.S. Md.</u> | | 25a. REC'D BY REGISTRAR <u>OCT 26 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|------------------------------|---------------------------------------|---|--|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 14169 | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD b. COUNTY MONT. | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
GAITHERSBURG 15-1 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
HOLY CROSS HOSPITAL | | | | | d. STREET ADDRESS
12 S. FREDERICK AVE. #106 | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print) HAZEL R. NORRIS | | | | | 4. DATE OF DEATH
Month 10 Day 8 Year 1967 | | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
7-17-08 59 yrs. | | 9. AGE (In years lost birthday)
59 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (County & State, or foreign country)
MASS | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Fredrick Ross | | | | | 14. MOTHER'S MAIDEN NAME
Totter Ryder | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Marie L. Antino, Gaithersburg, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) adrenal insufficiency
DUE TO (b) transfusion + severe infection
DUE TO (c) disseminated collagenosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs
1 wk
1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Rheumatoid arthritis | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3/1/67 , to 10/8/67 , that (I) (we) lost saw the deceased alive on 10/8/1967 , and that death occurred at 7:30 PM , from causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
Stephen N. Jones | | | | 22b. DATE SIGNED
10/9/67 | | | | 22c. PHYSICIAN'S NAME (Type)
STEPHEN N. JONES, M.D., F.A.C.P.
809 VICTORY RD., ROCKVILLE, MD 20850 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
Oct 10/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Fourth Oak | | | 23d. LOCATION (City or Town) (County) (State)
Gaithersburg, Md. | | |
| 24. FUNERAL DIRECTOR
Ernest C. Gartner
Ernest C. Gartner | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 13 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

10186

11111

STATE OF TEXAS

NOTICE

1911

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14168

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>D.O.A.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u> | | d. STREET ADDRESS <u>9101 Providence ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>John Charles Norman</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-8-20</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Supplier Self employed</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> | |
| 13. FATHER'S NAME <u>Charles John Norman</u> | | 14. MOTHER'S MAIDEN NAME <u>Genevieve Durang</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No xxx years</u> | | 16. SOCIAL SECURITY NO. <u>579-40-6325</u> | |
| 17. INFORMANT <u>Charles J. Norman</u> | | 18. ADDRESS OF INFORMANT <u>9110 Providence Ave Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>434.3</u> IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency accompanied</u>
DUE TO (b) <u>by acute laryngeal edema;</u>
DUE TO (c) <u>Chronic pericarditis</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Achondroplastic dwarf with multiple congenital anomalies.</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 22. ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>10/29/1967</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Nov. 1, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u> | |
| 24. FUNERAL DIRECTOR <u>John E. Thomas</u> 8434 Ardmore Avenue
<u>Warner E. Pumphrey, Inc.</u> Silver Spring, Md. | | 25. REG'D BY REGISTRAR <u>Charles J. Norman</u>
DATE <u>NOV 1 1967</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14165

14170

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|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN lb <u>24 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban HOSPITAL</u> | | d. STREET ADDRESS <u>7608 LEESBURG DRIVE</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Jacob</u> | | 4. DATE OF DEATH <u>Oct 30 1967</u> | |
| First Middle Last | | Month Day Year | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>W HITE</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JAN. 1894</u> | |
| 9. AGE (In years and months) <u>73</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>A TAILOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SHOP</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>MEYER OBCAS</u> | | 14. MOTHER'S MAIDEN NAME <u>RIFKA ?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>5810</u> | |
| 17. INFORMANT <u>MRS. FREDA OBCAS,</u> | | Address <u>7608 LEESBURG DR, BETHESDA, MARYLAND</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u>
DUE TO <u>Post Necrotic Cirrhosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1966</u> , to <u>Oct 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>29 Oct 1967</u> , and that death occurred at <u>12:02 AM</u> , from causes on the date stated above. | | | |
| 22a. SIGNATURE <u>Stanley M Bialek</u> | | 22b. DATE SIGNED <u>Oct. 30, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DR. STANLEY M. BIALEK</u> | | 22d. ADDRESS <u>8218 Wisc. Ave. Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10-30-1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>HAR ZION TIFERETH ISRAEL</u> | | 23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u> | |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD</u> | | 25a. REC'D BY REGISTRAR <u>DATE NOV 6 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
<i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
<i>Maryland</i> | | b. COUNTY
<i>Montgomery</i> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | | | | c. LENGTH OF STAY IN 1b
<i>27 years</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | | | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>10219 Ridgemoor Drive</i> | | | | | | d. STREET ADDRESS
<i>10219 Ridgemoor Drive</i> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<i>FLORENCE Brady</i> | | First | | Middle
<i>O'BRIEN</i> | | Last | | 4. DATE OF DEATH
<i>October 29 1967</i> | | Month Day Year | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>Nov. 17, 1909</i> | | 9. AGE (In years last birthday)
<i>57</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Frankfort, New York</i> | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | |
| 13. FATHER'S NAME
<i>Frank E. Brady</i> | | | | | | 14. MOTHER'S MAIDEN NAME
<i>Elizabeth Doyle</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>No</i> | | | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>John B. O'Brien, Jr.</i> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary Insufficiency - Progressive</i>
578x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
b) <i>Left Ventricular failure -</i>
c) <i>Granulomatous Colitis -</i> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>for years</i>
<i>1 wk</i>
<i>4 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<i>19</i> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1964</i> , 19 <i>Present</i> , 19 <i>Present</i> , that (I) (we) last saw the deceased alive on <i>Oct 13 1967</i> , and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<i>John D. Crummett, M.D.</i> | | | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>10/30/67</i> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>John D. Crummett</i> | | | | | | 22d. ADDRESS
<i>1746-K Street NW Wash. DC</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | | 23b. DATE THEREOF
<i>Oct. 31, 1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven</i> | | | | 23d. LOCATION (City, town or county) (State)
<i>Silver Spring, Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>C. Glen Carter</i> | | | | | | ADDRESS
<i>8434 Georgia Avenue</i> | | 25a. REC'D BY REGISTRAR
<i>Charles Judge</i> | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | DATE
<i>NOV 1 1967</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14167

14172

| | | | |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>M.D.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda Silver Spring 15-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Bethesda Silver Spring's Nursing Home</u> | | d. STREET ADDRESS
<u>104 E Lenox St Ch/ch</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Agatha T. O'Donoghue</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>24</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12/12/74</u> |
| 9. AGE (In years last birthday)
<u>92</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>9</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Housewife</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>VA.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Mahoney</u> | | 14. MOTHER'S MAIDEN NAME
<u>Bridget Larkin</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>---</u> | |
| 17. INFORMANT
<u>Mrs. Stephen W. Nealon, 104 E. Lenox St. Chevy Chase, Md.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>
DUE TO
(b) <u>Arteriosclerotic Heart Disease</u>
DUE TO
(c) <u>Generalized Arteriosclerosis</u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH
<u>2 hrs</u>
<u>10 yrs</u>
<u>unknown</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>---</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1957, to <u>Oct</u> , 1967, that (I) (we) last saw the deceased alive on <u>10/24</u> 1967, and that death occurred at <u>6:05 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>James J. Foster</u> | | 22b. DATE SIGNED
<u>10/24/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. James J. Foster</u> | | 22d. ADDRESS
<u>1746 "K" Street, N.W. Wash. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>10-26-1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D.C.</u> | |
| 24. FUNERAL DIRECTOR
<u>Joe Smith's Sons, Thos. Ave., N.W. Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 26 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles J. Jones</u> | | | |

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DEATH OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14168

14173

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>JOHN</u> First Middle Last | | 4. DATE OF DEATH <u>Oct 23</u> 19 <u>67</u> Month Day Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 6, 1896</u> 71 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Smith Development</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Ala</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Nash Ollie</u> | | 14. MOTHER'S MAIDEN NAME <u>Maria P</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>578073441</u> | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency -</u>
DUE TO (b) <u>Cardiovascular Disease -</u>
DUE TO (c) <u>years -</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John W. Ball</u> | | 22. DATE SIGNED <u>Oct 23/67</u> | |
| EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>10/30/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park, Landover Md.</u> | 23d. LOCATION (City or town) (County) (State) |
| 24. FUNERAL DIRECTOR <u>Johnson & Jenkins 4804 Ga Ave N.W. D.C.</u> | | 25a. REC'D BY REGISTRAR <u>Oct 23 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u> | |

EX 111

11111

[Faint, illegible handwriting and markings across the page, possibly bleed-through from the reverse side.]

14169

CERTIFICATE OF DEATH

14174

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Med. Examiner

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| c. LENGTH OF STAY IN 1b <u>DOA</u> | | d. STREET ADDRESS <u>1110 Schindler Drive</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>William</u> First <u>(NMN)</u> Middle <u>O'Malley</u> Last | | 4. DATE OF DEATH <u>October</u> Month <u>18</u> Day <u>19</u> Year <u>67</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 16, 1913</u> 9. AGE (In years last birthday) <u>54</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Driver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Products</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Anthony O'Malley</u> | | 14. MOTHER'S MAIDEN NAME <u>Bridget Hughes</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u> | | 16. SOCIAL SECURITY NO. <u>236-18-8798</u> | |
| 17. INFORMANT <u>Catherine K. O'Malley</u> Address <u>1110 Schindler Drive Silver Spring, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4201 IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
DUE TO (b) <u>Coronary Artery Disease</u>
DUE TO (c) <u>Arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
<u>3 yrs.</u>
<u>"</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> , 19 <u>57</u> to <u>Oct 18</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Sept 17</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>R. A. Yates MD</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>10/18/67</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>R. A. YATES</u> | | 22d. ADDRESS <u>OLNEY, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Oct. 21, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>OCT 23 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

11111

ESTIMATE OF DATE

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DEC 23 1967

CERTIFICATE OF DEATH

14175

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ROCKVILLE | | c. LENGTH OF STAY IN 1b
15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
624 Blossom Drive | | d. STREET ADDRESS
624 Blossom Drive | |
| 3. NAME OF DECEASED (Type or print)
JEANNE AGNES OSBAHR | | 4. DATE OF DEATH
Month OCTOBER Day 23 Year 1967 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 6, 1930 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
37 yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
Philadelphia Pa | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
John Culliton | | 14. MOTHER'S MAIDEN NAME
Helen Zeiss | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Husband | | 17. INFORMANT (Address)
Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
201x
IMMEDIATE CAUSE (a) Hodgkins DISEASE
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) | | INTERVAL BETWEEN ONSET AND DEATH
3+ years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from January 1964 to Oct 23, 1967 , that (I) (we) last saw the deceased alive on April 1967 and that death occurred at 9 P.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
HERMAN C. MAGANZINI | | 22b. DATE SIGNED
10/23/67 | |
| 22c. PHYSICIAN'S NAME (Type)
HERMAN C. MAGANZINI | | 22d. ADDRESS
50 W. Edmonston Dr, Rockville | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10-26-67 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Maryland |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
OCT 26 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CHURCH OF LENTH

1811

636 Blomson Drive

Teacher

John Wilkerson

John Wilkerson, Jr.

636 Blomson Drive

10-26-57 Date of Birth

JOHN WILKERSON, JR. Pasadena, Maryland

Oct 27 1957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
KENSINGTON | | c. LENGTH OF STAY IN 1b
15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SUBURBAN | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) George MARSHALL OVERS | | 4. DATE OF DEATH OCT 6 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 6-1904 62 |
| 9. AGE (In years lost birthday) yrs. 62 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Foreman TRACK | | 10b. KIND OF BUSINESS OR INDUSTRY BARNEVILLE, Md. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME JAMES HENRY | | 14. MOTHER'S MAIDEN NAME Molly Elizabeth JACKSON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Louise OVERS - BARNEVILLE, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4344 IMMEDIATE CAUSE (a) Cardiac Arrhythmia.
DUE TO (b) Cardiac Hypertrophy + Dilatation.
DUE TO (c) years - | | | INTERVAL BETWEEN ONSET AND DEATH years - |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John G. Ball M.D. | | 22. DATE SIGNED 10/6/67 | |
| EXAMINER'S NAME (Type) | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10/10/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) CLARKSBURG, Montg. Md. | |
| 24. FUNERAL DIRECTOR Robert L. Snowden Rockville, Md. | | 25a. REC'D BY REGISTRAR OCT 10 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE John Charles Judge | |

George Washington
Mar. 1800
George Washington
Mar. 1800

James Henry
Mar. 1800
James Henry
Mar. 1800

James Henry
Mar. 1800
James Henry
Mar. 1800

James Henry
Mar. 1800
James Henry
Mar. 1800

CERTIFICATE OF DEATH

Reg. Dist. No.

14172

14177

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | | c. LENGTH OF STAY IN lb
<u>25 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>4515 Highland Ave.</u> | | | | d. STREET ADDRESS
<u>4515 Highland Ave.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>SAMUEL</u> Middle <u>R.</u> Last <u>PAINTER</u> | | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>14</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 22, 1899</u> | | 9. AGE (In years last birthday)
<u>68</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>Edward G. Painter</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>(Unknown) Morris</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>215-44-8255</u> | | 17. INFORMANT <u>Wife</u>
<u>Edith Painter</u> | | Address
<u>Same as Item 2.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of bladder</u>
<u>1810</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.
(b) _____
DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 1, 1967</u> , to <u>Oct 14, 1967</u> , that I last saw the deceased alive on <u>Oct 13, 1967</u> , and that death occurred at <u>6:05 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Dr Joseph Kennick</u> | | | | ADDRESS (Street, city or town, state)
<u>6450 Wisconsin Ave, Bethesda, Md.</u> | | DATE SIGNED
<u>10/14/67</u> | |
| PHYSICIAN'S NAME (Type)
<u>Dr JOSEPH P. KENRICK</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10-18-67</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Rosewood Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Lewisburg, West Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>OCT 18 1967</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14178

| | | | |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>1821 Powder Mill Rd.</u> | | d. STREET ADDRESS <u>1821 Powder Mill Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Gladys</u> First Middle Last <u>(NMN)</u> <u>PARKS</u> | | 4. DATE OF DEATH Month <u>OCT</u> Day <u>7</u> Year <u>1967</u> | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 14, 1925</u> 42 yrs. |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTY SHOP OPERATOR</u> | | 9b. KIND OF BUSINESS OR INDUSTRY | |
| 10a. BIRTHPLACE (State or foreign country) <u>D.C.</u> | | 10b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 11. FATHER'S NAME <u>THOMAS BANKS</u> | | 12. MOTHER'S MAIDEN NAME <u>LORETTA MANNING</u> | |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 14. SOCIAL SECURITY NO. <u>—</u> | |
| 15. INFORMANT <u>MOTHER</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute coronary thrombosis</u>
DUE TO
(b) <u>Coronary artery heart disease</u>
DUE TO
(c) <u>—</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>Oct. 7, 1967</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> | | DEPUTY MEDICAL EXAMINER <u>—</u> Address Street City Town County | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>10-12-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore MD</u> |
| 24. FUNERAL DIRECTOR <u>As Washington Son 4925 N. Ave One NE</u> | | 25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u> DATE <u>OCT 16 1967</u> | |

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14176

14179

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring D.O.A.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | d. STREET ADDRESS <u>8505 Springvale Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>SAMUEL OSCAR PECK</u> | | 4. DATE OF DEATH <u>10 - 14 19 67</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-24-88</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Hugh T. Peck</u> | | 14. MOTHER'S MAIDEN NAME <u>Charlton</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>578-10-9449</u> | |
| 17. INFORMANT (SON) <u>Hugh T. Peck</u> | | 18. ADDRESS <u>10511 DENEANE RD, Silver Spring</u> | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u>
DUE TO (b) <u>Coronary Artery Heart Disease</u>
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____
p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>10-14-1967</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (State, city, and county) _____ | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Oct 17, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) _____ (County) _____ (State) <u>Switland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>OCT 19 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

14175

CERTIFICATE OF DEATH

14180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN 1b
<u>3 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Maryland</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Lorine</u> Middle <u>Lillian</u> Last <u>Peterson</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>30</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>14 May 1907</u> |
| 9. AGE (In years lost birthday) yrs.
<u>60</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Jud Lair</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lillian Miller</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>360-28-8890</u> | |
| 17. INFORMANT
<u>The Medical Records</u> | | 18. ADDRESS
<u>The Clinical Center, Bethesda, Maryland</u> | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>2891</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO
(b) <u>Hypoxia and Pulmonary Bleeding</u>
DUE TO
(c) <u>Endobronchial Amyloidosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>2 hours</u>
<u>20 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> o.m. p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>27 October, 1967</u> , to <u>30 Oct., 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>30 October 1967</u> , and that death occurred at <u>1:20 M</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Henry Benfer Kaltreider, MD</u> | | 22b. DATE SIGNED
<u>Oct. 30, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Henry Benfer Kaltreider, M.D.</u> | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | 23b. DATE THEREOF
<u>10-31-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Suitland Prince Georges</u> |
| 24. FUNERAL DIRECTOR
<u>Robert A Pumphrey</u> | | 25. REC'D BY REGISTRAR
<u>7557 Adamsconsin Ave Bethesda, Md</u> | |
| 25a. DATE
<u>NOV 3 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

[illegible]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14181

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Damascus -</u> | | c. LENGTH OF STAY IN 1b
<u>3 mo.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Route 2, Brecken's Creamery Rd.</u> | | d. STREET ADDRESS
<u>Route #2, Hawthorn's Creamery Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>John James Petri</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>5</u> Year <u>1967</u> | |
| 5. SEX
<u>M.</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 25, 1926</u> |
| 9. AGE (In years lost birthday)
<u>41</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Production Foreman</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Mass.</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Frank P. Petri</u> | | 14. MOTHER'S MAIDEN NAME
<u>Margaret C. Frank</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>010-20-7422</u> | |
| 17. INFORMANT
<u>Wife</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u>
DUE TO (b) <u>Cardio Vascular Disease.</u>
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>Several</u>
<u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>John G. Ball</u> | | 22. DATE SIGNED
<u>10/5/67</u> | |
| EXAMINER'S NAME (Type)
<u>John G. Ball, M.D.</u> | | Address (Street, city, town, or county)
<u>Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Oct. 9, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>South View</u> | 23d. LOCATION (City or Town) (County) (State)
<u>North Adams, Mass.</u> |
| 24. FUNERAL DIRECTOR
ADDRESS
<u>Olin L. Molesworth, Damascus, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 9 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

1214

2532

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| | | | | | |
|--|--|---|---|---|---|
| 14173 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 14182 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WHEATON</u> | | c. LENGTH OF STAY IN 1b
<u>8 DAYS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>RANDOLPH HILLS NURSING HOME</u> | | | d. STREET ADDRESS
<u>3602 Kenway Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First <u>FLORA</u> Middle <u>A.</u> Last <u>PETZOLD</u> | | | 4. DATE OF DEATH
Month <u>OCT.</u> Day <u>12</u> Year <u>19 67</u> | | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>JAN. 9, 1897</u> | 9. AGE (In years lost birthday)
<u>73</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Peoria, Illinois</u> | |
| 13. FATHER'S NAME
<u>George Willms</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | | 14. MOTHER'S MAIDEN NAME
<u>M. Harms</u> | | |
| 16. SOCIAL SECURITY NO.
<u>220-44-2701</u>
<u>yes</u> | | 17. INFORMANT
<u>Richard Petzold</u> <u>9412 Russell Road</u>
<u>Silver Spring, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY ARTERY OCCUSION</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>CORONARY ARTERY DISEASE</u>
DUE TO
(c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>15 MIN.</u>
<u>3 YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>ARTHRITIS, RHEUMATOID, ADVANCED, CHRONIC (2) Recent Peptic ulcer</u> | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/11, 1964</u> , to <u>10/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>10/12, 1967</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>James A. Roberts</u> | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>OCT. 12, 1967</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>JAMES A. ROBERTS M.D.</u> | | | 22d. ADDRESS
<u>8907 GEORGIA AVE. SILVER SPRING, MD.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Oct. 14, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc.</u> | | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14183

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | c. LENGTH OF STAY IN 1b
1 Year | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
10500 Rockville Pike, Apt. 415 | | e. STREET ADDRESS
10500 Rockville Pike | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
HERMAN JOSEPH PFUNDSTEIN | | 4. DATE OF DEATH
Month Day Year
October - 26 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 6, 1906 |
| 9. AGE (In years last birthday) yrs.
60 | | 10. IF UNDER 1 YEAR
Months Days
26 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman - Drug Fair | | 10b. KIND OF BUSINESS OR INDUSTRY
Brooklyn, New York | |
| 11. BIRTHPLACE (County & State, or foreign country)
U. S. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Anthony Pfundstein | | 14. MOTHER'S MAIDEN NAME
Elizabeth Bayer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
577-09-7136 | |
| 17. INFORMANT
Wife | | Address
Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute
DUE TO
(b) Cardio-Vascular Disease -
DUE TO
(c) Arterio-Sclerosis - Generalized - | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
Years.
Years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from 1963 , to date , 19 67 , that (I) (we) last saw the deceased alive on 29 Sept 19 67 , and that death occurred at early AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John S. Ball | | 22b. DATE SIGNED
10-26-67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN G. BALL | | 22d. ADDRESS
7936 Old Georgetown Rd - Bethesda, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-30-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Maryland | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
DATE OCT 30 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

Montgomery

Montgomery

Montgomery

Rockville

1 Year

Rockville

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1950 Rockville, Md.

1950 Rockville, Md.

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1950-57

1950-57, 1950-57, 1950-57

14178

14181

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA
c. LENGTH OF STAY IN 1b
43 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
MOUNT AIRY | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
NAVAL MEDICAL CENTER | | d. STREET ADDRESS
ROUTE #1
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Doris Marie PONCE | | 4. DATE OF DEATH
Month Day Year
OCTOBER 30 19 67 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
CAUC. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 28, 1930 |
| 9. AGE (In years lost birthday)
37 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
WASHINGTON, D.C. |
| 13. FATHER'S NAME
EMMETT DOWNING BROWN | | 14. MOTHER'S MAIDEN NAME
KEREN M. JONES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
578 40 8079 | |
| 17. INFORMANT HUSBAND
HECTOR G. PONCE | | Address
SAME AS # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cloacogenic Squamous Cell Carcinoma of Rectum
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) _____
DUE TO
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCT 19 , 19 67 , to 30 OCT , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on OCTOBER 30 , 19 67 , and that death occurred at 7:23 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>William R. Hix</i> | | 22b. DATE SIGNED
31 OCT 67 | |
| 22c. PHYSICIAN'S NAME (Type) William R. HIX, M. D. | | 22d. ADDRESS
NAVAL HOSPITAL, BETHESDA, MD. | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
BURIAL | 23b. DATE THEREOF
NOV. 2-67 | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEM. | 23d. LOCATION (City or Town) (County) (State)
ARLINGTON, VIRGINIA |
| 24. FUNERAL DIRECTOR
ADDRESS
COLLINS FUNERAL HOME, 3821 14th Street, NW
<i>J. Collins</i>
WASHINGTON, D. C. | | 25a. REC'D BY REGISTRAR
NOV 2 1967 | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

14175

CHRONICALLY ILL

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
<u>Montgomery</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY
<u>Washington, DC</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN lb
<u>93 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington, DC</u> | | 47-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Suburban Hospital</u> | | d. STREET ADDRESS
<u>200 Rhode Island Ave. N.E.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>Bessie</u> <u>Poss</u> | | 4. DATE OF DEATH
Month Day Year
<u>Oct</u> <u>16</u> <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12/27/12</u> |
| 9. AGE (In years last birthday)
<u>88</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Food Checker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Hotel</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Wallace Davis</u> | | 14. MOTHER'S MAIDEN NAME
<u>Janie Cook</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>579-10-0907A</u> | |
| 17. INFORMANT
<u>Mrs. Janie White</u> | | Address
<u>Wash., DC</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHO PNEUMONIA</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>COMPLICATIONS OF GASTRECTOMY</u>
DUE TO
(c) <u>CARCINOMA STOMACH</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 DAYS</u>
<u>14 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>ATHEROSCLEROSIS GENERAL AND CEREBRAL</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 18</u> , 19 <u>67</u> , to <u>OCT. 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>OCT. 15</u> , 19 <u>67</u> , and that death occurred on <u>OCT. 16</u> , 19 <u>67</u> , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Robert G. Angle</u> | | 22b. DATE SIGNED
<u>OCT. 16, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>10/18/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Bethel</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Alexandria, Va.</u> | |
| 24. FUNERAL DIRECTOR
<u>Walter J. Hall</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 17 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

MISS

MISS



125A

Virginia

Hotel

Food Director

Miss Cook

William Davis

Wash., DC

Mrs. Annie White

570-10-0007A

Ed

Alexander, Jr.

Robert

10/18/67

Wm. J.

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY in ib <u>42 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>6104 Stardust Lane</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>ROSAMOND HUNT PRICE</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>6/22/13</u> |
| 9. AGE (In years last birthday) <u>54</u> yrs. | | IF UNDER 1 YEAR
Months <u>3</u> Days <u>16</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed - Revenues</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT & S. Inc.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda - Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George Henry G. Hunt</u> | | 14. MOTHER'S MAIDEN NAME <u>Annand Harder</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | |
| 17. INFORMANT <u>Supervisor</u> | | 18. ADDRESS <u>5225 West Pathway</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u>
DUE TO (b) <u>1621</u>
DUE TO (c) <u>3 months</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u>
p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 5th</u> , 19 <u>67</u> , to <u>10-31-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-31-</u> 19 <u>67</u> , and that death occurred at <u>6:59 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Stephen W. Deiter</u> | | 22b. DATE SIGNED <u>10/31/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>STEPHEN W. DEITER, M.D.</u> | | 22d. ADDRESS <u>6719 WILSON LANE, BETHESDA, MD 20834</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>11-3-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rockville, Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Joseph Gawler's Sons, Inc.</u>
<u>5130 Wisc. Ave. N.W. Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 6 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14182

CERTIFICATE OF DEATH

14187

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
<u>MONTGOMERY</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<u>DC</u>
b. COUNTY
<u>47-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TAKOMA PARK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington SAN & Hosp</u> | | d. STREET ADDRESS
<u>1411 Spring Rd., NW</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>BETHEL</u>
First Middle Last
<u>NONE</u> <u>PHILLIAM</u> | | 4. DATE OF DEATH
Month Day Year
<u>10</u> <u>26</u> <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10-29-94</u> |
| 9. AGE (In years lost birthday)
<u>72</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HSWT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>JAMES CRANTZ</u> | | 14. MOTHER'S MAIDEN NAME
<u>Judy Updike</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>CHART</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
DUE TO
(b) <u>Hemorrhage</u>
DUE TO
(c) <u>Severe Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
INTERVAL BETWEEN ONSET AND DEATH
<u>10-10-67</u>
<u>10-10-67</u>
<u>Months</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Severe Congestive Heart Failure</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 1961, to <u>October 26</u> , 1967, that (I) (we) last saw the deceased alive on <u>October 25</u> , 1967, and that death occurred at <u>7:03 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Stuart L. Nelson</u> | | 22b. DATE SIGNED
<u>10-26-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>STUART L. NELSON</u> | | 22d. ADDRESS
<u>University Blvd. E Silver Spring Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Oct. 30. 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Annapolis Pr. Geo. Co. Md</u> |
| 24. FUNERAL DIRECTOR
<u>Arthur Walters</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>OCT 27 1967</u> | |

1957

UNITED STATES DEPARTMENT OF AGRICULTURE

BRILL

1957, 12, 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|--|--|--|--|---|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 14183 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 14188 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | | | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Oiney | | | | | | c. LENGTH OF STAY IN 1b
D.O.A. | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg | | | | | | 151 | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montgomery General Hospital | | | | | | | | | | | | d. STREET ADDRESS
111 Central Ave. | | | | | | | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Dora Middle Estelle Last Purdum | | | | | | | | | | | | 4. DATE OF DEATH
Month Oct. Day 8 Year 19 67 | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 17, 1899 | | | | 9. AGE (In years lost birthday) yrs.
68 | | | | IF UNDER 1 YEAR
Months Days Hours Min. | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | | 11. BIRTHPLACE (County & State, or foreign country)
Cedar Grove, Md. | | | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME
James W. Johnson | | | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
Emma C. Burdette | | | | | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | | | 16. SOCIAL SECURITY NO.
220-54-1122 | | | | | | 17. INFORMANT
Harry Lee Purdum, Item 2 | | | | | | Address | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201 IMMEDIATE CAUSE (a) Acute Coronary Thrombosis
DUE TO (Anterior)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Atherosclerosis - Gen'l -
DUE TO Severe
(c) Cardiomegaly | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Minutes
Years | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1949 to Present , that (I) was last saw the deceased alive on Oct. 1 1967 , and that death occurred at 5:00 M, from causes on and the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Jack Schumacher M.D. | | | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | 22b. DATE SIGNED
10-9-67 | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Jack Schumacher, M.D. | | | | | | | | | | | | 22d. ADDRESS
105 Russell Ave., Gaithersburg, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | 23b. DATE THEREOF
Oct. 10, 1967 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn | | | | | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Md. | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, Damascus, MD. | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 13 1967 | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | |

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Item 18 Film 3307 2/2/68 11
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|----------------------------------|---|--|---|---|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | c. LENGTH OF STAY IN lb
2 Yrs. 9 Mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Potomac Valley Nursing Home | | | | d. STREET ADDRESS 5907 Rolston Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
THOMAS Walter PYLE | | | | 4. DATE OF DEATH
Month Oct. Day 9, Year 19 67 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 7, 1888 | 9. AGE (In years last birthday)
79 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Asst. Supt. Public Schools- Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
William Stamp Pyle | | | | 14. MOTHER'S MAIDEN NAME
Mary Price Hoopes | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
219-36-7682 | | 17. INFORMANT Wife
Helen D. Pyle | | Address
Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
331X
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
DUE TO Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Coronary | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Oct 9 1967
Years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1956 , 19 to Present , 19 that (I) (we) last saw the deceased alive on Oct 7 19 67 , and that death occurred at 7P M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
George Sharpe | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE SHARPE | | | | 22d. ADDRESS
10400 Conn. Ave. Kensington, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-12-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Broad Creek Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hartford County, Md. | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a. REC'D BY REGISTRAR
OCT 16 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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